Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

| Statu | tory Services (check each | ch that applies) | | | | |
|---|---|------------------|---|--|--|--|
| | Service | Included | Alternate Service Title (if any) | | | |
| Case | Management | | | | | |
| Home | emaker | | | | | |
| Home | e Health Aide | | | | | |
| Perso | nal Care | | | | | |
| Adult | Day Health | X | Medical Day Care | | | |
| Habil | itation | X | Personal Supports | | | |
| Resid | ential Habilitation | | | | | |
| Day I | Habilitation | X | | | | |
| Prevocational Services | | | | | | |
| Supported Employment | | X | 1- Supported Employment2- Transitional Employment Services | | | |
| Education | | | | | | |
| Respite | | X | Respite Care Service | | | |
| Day Treatment | | | | | | |
| Partial Hospitalization | | | | | | |
| Psych | osocial Rehabilitation | | | | | |
| Clinic | Services | | | | | |
| Live-in Caregiver (42 CFR §441.303(f)(8)) | | | | | | |
| Othe | r Services (select one) | | | | | |
| 0 | Not applicable | | | | | |
| X | As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (<i>list each service by title</i>): | | | | | |
| a. | Assistive Technology and Services | | | | | |
| b. | Behavioral Support Services | | | | | |

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| c. | Community Development Servi | ices | | | | |
|-------|---|-----------------|----------------------------------|--|--|--|
| d. | Environmental Assessment | | | | | |
| e. | Employment Discovery & Cust | omization | | | | |
| f. | Environmental Modifications | | | | | |
| g. | Family and Peer Mentoring Sup | ports | | | | |
| h. | Family Caregiver Training & E | mpowermen | at Services | | | |
| i | Individual & Family Directed C | Goods and Se | ervices | | | |
| j | Participant Education, Training | , & Advocac | cy Supports | | | |
| k. | Support Broker Services | | | | | |
| 1. | Transportation | | | | | |
| m. | Vehicle Modifications | | | | | |
| Exte | nded State Plan Services (select | one) | | | | |
| X | Not applicable | | | | | |
| 0 | The following extended State plan services are provided (list each extended State plan service by service title): | | | | | |
| a. | | | | | | |
| b. | | | | | | |
| C. | eauta fan Dantiainant Dinaction (| (ah a ah a g ah | Abat annlias) | | | |
| O | The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services. | | | | | |
| X | The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E. | | | | | |
| 0 | Not applicable | | | | | |
| | Support | Included | Alternate Service Title (if any) | | | |
| | formation and Assistance in X Support Broker Coordination of Community Services | | | | | |
| Finar | nancial Management Services X Fiscal Management Services | | | | | |
| Othe | r Supports for Participant Direction | on (list each | support by service title): | | | |
| a. | | | | | | |
| b. | | | | | | |
| | | | | | | |

C-1/C-3: Service Specification

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State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type: Other Service

Service (Name):

Alternative Service Title: ASSISTIVE TECHNOLOGY AND SERVICES

| Service | Specification |
|--|--------------------------------|
| HCBS Taxonomy | |
| Category 1: | Sub-Category 1: |
| 14: Equipment, Technology, and Modifications | 14031 equipment and technology |
| Service Definition (Scope): | |

- A. The purpose of assistive technology is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, promote their ability to live independently, and meaningfully participate in their community.
- B. Assistive technology means an item, piece of equipment, or product system. Assistive Technology may be acquired commercially, modified, or customized. Assistive technology devices include but are not limited to:
 - 1. Speech and communication devices also known as augmentative and alternative communication devices (AAC) such as speech generating devices, text-to-speech devices and voice amplification devices;
 - 2. Blind and low vision devices such as video magnifiers, devices with optical character recognizer (OCR) and Braille note takers;
 - 3. Deaf and hard of hearing devices such as alerting devices, alarms, and assistive listening devices;
 - 4. Devices for computers and telephone use such as alternative mice and keyboards or hands-free phones;
 - 5. Environmental control devices such as voice activated lights, lights, fans, and door openers;
 - 6. Aides for daily living such as weighted utensils, adapted writing implements, dressing aids;
 - 7. Cognitive support devices such as task analysis applications or reminder systems;
 - 8. Remote support devices such as remote health monitoring and personal emergency response systems;
 - 9. Adapted toys and specialized equipment such as specialized car seats and adapted bikes.
- C. Assistive technology service means a service that directly assists a participant in the selection, acquisition, use, or maintenance of an assistive technology device. Assistive technology services include:
 - 1. Assistive Technology needs assessment;
 - 2. Training or technical assistance for the participant and their support network including family members;
 - 3. Repair and maintenance of devices and equipment;
 - 4. Programming and configuration of devices and equipment;
 - 5. Coordination and use of assistive technology devices and equipment with other necessary therapies, interventions, or services in the person-centered plan; and
 - 6. Services consisting of purchasing or leasing devices.
- D. Specifically excluded under this service are:
 - 1. Wheelchairs and power mobility, architectural modifications, adaptive driving, vehicle modifications, and devices requiring a prescription by physicians or medical providers as these items are covered either through the Medicaid State Plan as Durable Medical Equipment (DME), a stand-alone waiver services (i.e. environmental modification and vehicle modifications), or through DORS; and
 - 2. Services, equipment, items or devices that are experimental or not authorized by the State or Federal authority.

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SERVICE REOUIREMENTS:

- A. Assistive Technology, recommended by the team that costs up to \$1,000 per item does not require a formal assessment.
- B. Assistive technology devices of \$1,000 or more must be recommended by an independent evaluation of the participant's assistive technology needs.
- C. The evaluation must include the development of a list of all devices, supplies, software, equipment, product systems and/or waiver services (including a combination of any of the elements listed) that would be most effective to meet the need(s) of the participant. The least expensive option from the list must be selected for inclusion on the person-centered plan.
- D. When services are furnished to individuals returning to the community from a Medicaid institutional setting, the costs of such services are considered to be incurred and billable when the individual leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition); services may be billed to Medicaid as an administrative cost.
- E. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the participant's file.
- F. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

| consistent with | consistent with waiver objectives of avoiding institutionalization. | | | | | | | | | |
|---|---|--|-----------|---|----------|--------------------------|-------------------------------------|---|--|---|
| Specify applicable | (if any) | limits | on the an | nount, frequen | cy, or | duratio | n of this s | ervice: | • | |
| | | | | | | | | | | |
| Service Delivery Method (check each that applies): | ch | X | Participa | ant-directed as | s specif | fied in | Appendix | Е | X | Provider managed |
| Specify whether the service may be provided by (check each that applies): Legally Relative Relative Legal Guardian | | | | | Guardian | | | | | |
| | | | | Provider Sp | ecifica | tions | | | | |
| Provider | X Individual, List types | | | List types: | | X | Agency. List the types of agencies: | | | es of agencies: |
| Category(s) (check one or both): | Certified professio | articipants self-directing services - fied specialists, licensed ssionals, or DORS approved vendor l on service requested | | DDA Certified Organized Health Care Delive System Provider | | | alth Care Delivery | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Provider Qualifica | ations • | | | | | | | | | |
| Provider Type: | License (specify) Certificate (sp | | | e (spec | rify) | Other Standard (specify) | | | | |
| Agency or individual for participant self-directing services | | | | | | | entity per qualificate to the ser | forming tions notice be organized | ng the second to detect the detect of the de | the individual or ervice meets the ow as applicable vided: r professional ation shall be |

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| | 3. | credentialed, licensed, or certified in an area related to the specific type of technology needed. The evaluation must include the development of a list of all devices, supplies, software, equipment, product systems and/or waiver services (including a combination of any of the elements listed) that would be most effective to meet the need(s) of the participant. The least expensive option from the list must be selected for inclusion on the person-centered plan. Assistive Technology assessments, with the exception for Speech Generating Devices, must be completed by a specialist that has any of the following certifications as appropriate: a. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Assistive Technology Practitioner (ATP), b. California State University Northridge (CSUN) Assistive Technology Applications Certificate, or c. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP). Assessment for Speech Generating Devices (SGD): a. Need assessment and recommendation must be completed by a licensed Speech Therapist; b. Program and training can be conducted by a RESNA Assistive Technology Practitioner (ATP) or California State University c. North Ridge (CSUN) Assistive Technology Applications Certificate professional. |
|--|----|---|
| | 4. | Technology Applications |
| | | acceptable certification from any of the following: a. Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) |
| | | TOTAL THICHCA (RESIVA) |

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| | | Assistive Technology Practitioner (ATP); b. California State University Northridge (CSUN) Assistive Technology Applications Certificate; or c. Certificate of Clinical Competence in Speech Language Pathology (CCC-SLP); d. Minimum of three years of professional experience in adaptive rehabilitation technology in each device and service area certified; and e. Licensed professional must have: 1) Maryland Board of Audiologists, Hearing Aid Dispensers & Speech- Language Pathologists license for Speech-Language Pathologist, or 2) Maryland Board of Occupational Therapy Practice license for Occupational Therapist or 5. Entity designated by the Division of Rehabilitation Services (DORS) as an Assistive Technology service vendor. |
|--|--|---|
| DDA Certified Organized Health Care Delivery System Provider | DDA certified Organized Health Care Delivery System (OHCDS) provider as per COMAR Title 10, Subtitle 22. | OHCDS providers shall verify the licenses, credentials, and experience of all professionals with whom they contract or employs and have a copy of the same available upon request. OHCDS must ensure the individual or entity performing the service meets the qualifications noted below as applicable to the service being provided: 1. The organization or professional providing the evaluation shall be credentialed, licensed, or certified in an area related to the specific type of technology needed. The evaluation must include the development of a list of all devices, supplies, software, equipment, product systems and/or waiver services (including a combination of any of the elements listed) that would be most effective to meet the need(s) of the participant. The least expensive option from the list must be selected for inclusion on |

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| | 2 | the person-centered plan. |
|--|----|--|
| | 2. | Assistive Technology assessments, |
| | | with the exception for Speech |
| | | Generating Devices, must be |
| | | completed by a specialist that has any |
| | | of the following certifications as |
| | | appropriate: |
| | | a. Rehabilitation Engineering and |
| | | Assistive Technology Society of |
| | | North America (RESNA) |
| | | Assistive Technology |
| | | Practitioner (ATP), |
| | | b. California State University |
| | | Northridge (CSUN) Assistive |
| | | Technology Applications |
| | | Certificate, or |
| | | c. Certificate of Clinical |
| | | Competence in Speech Language |
| | | Pathology (CCC-SLP). |
| | 3. | Assessment for Speech Generating |
| | | Devices (SGD): |
| | | a. Need assessment and |
| | | recommendation must be |
| | | completed by a licensed Speech |
| | | Therapist; |
| | | b. Program and training can be |
| | | conducted by a RESNA |
| | | Assistive Technology |
| | | Practitioner (ATP) or California |
| | | State University |
| | | c. North Ridge (CSUN) Assistive |
| | | Technology Applications |
| | | Certificate professional. |
| | 4. | Assistive Technology |
| | | Specialist/Practitioner must have an |
| | | acceptable certification from any of |
| | | the following: |
| | | a. Rehabilitation Engineering and |
| | | Assistive Technology Society of |
| | | North America (RESNA) |
| | | Assistive Technology Practitioner |
| | | (ATP); |
| | | b. California State University |
| | | Northridge (CSUN) Assistive |
| | | Technology Applications |
| | | Certificate; or |
| | | c. Certificate of Clinical |
| | | Competence in Speech Language |
| | | Pathology (CCC-SLP); |
| | | d. Minimum of three years of |
| | | professional experience in |
| | | adaptive rehabilitation technology |

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| | | in each device and service area certified; and e. Licensed professional must have: 1) Maryland Board of Audiologists, Hearing Aid Dispensers & Speech- Language Pathologists license for Speech-Language Pathologist, or 2) Maryland Board of Occupational Therapy Practice license for Occupational Therapist or 5. Entity designated by the Division of Rehabilitation Services (DORS) as an Assistive Technology service vendor. |
|---|---|---|
| Verification of Pro | vider Qualifications | |
| Provider Type: | Entity Responsible for Ver | rification: Frequency of Verification |
| Individual for participant self-directing services | FMS provider, as described in App | FMS provider - prior to services |
| DDA Certified Organized Health Care Delivery System Provider | DDA for OHCDS certificate OHCDS providers for entities a they contract or employ | 1. OHCDS certificate - annually 2. OHCDS providers – prior to service delivery |

Service Type: Other Service (Name):

Alternative Service Title: BEHAVIORAL SUPPORTS SERVICES

| Service Specification | | | | |
|--|-----------------|--|--|--|
| HCBS Taxonomy | | | | |
| Category 1: | Sub-Category 1: | | | |
| 10: Other Mental Health and Behavioral Services 10040 behavior support | | | | |
| Service Definition (Scope): | | | | |

- A. Behavioral Supports Services are an array of services to assist participants who without such supports are experiencing, or are likely to experience, difficulty in community living as a result of behavioral, social, or emotional issues. These services seek to help understand a participant's challenging behavior and what need it is communicating in order to develop a Behavior Plan with the primary aim of enhancing the participant's independence and inclusion in their community.
- B. Behavioral Supports Services includes:
 - 1. Behavioral Assessment identifies a participant's challenging behaviors and identifies co-occurring mental health issues that contribute to those behaviors, by collecting and reviewing relevant data, discussing the information with the participant's support team, and developing a Behavior Plan, if needed;

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- 2. Behavioral Consultation services that oversee, monitor, and modify the Behavior Plan; and
- 3. Brief Support Implementation Services time limited service to provide direct assistance and modeling to families, agency staff, and caregivers so they can independently implement the Behavior Plan.

SERVICE REQUIREMENT:

A. Behavioral Assessment:

- 1. Is based on the principals of person-centered thinking, a comprehensive Functional Behavioral Assessment (FBA), and supporting data;
- 2. Is performed by a qualified clinician;
- 3. Requires development of specific hypotheses for the challenging behavior, a description of the challenging behaviors in behavioral terms, and the topography, frequency, duration, intensity/severity, and variability/cyclicality of the behaviors;
- 4. Must be based on a collection of current specific behavioral data; and
- 5. Includes the following:
 - a. An onsite observation of the interactions between the participant and his/her caregiver(s) in multiple settings and observation of the implementation of existing programs;
 - b. An environmental assessment of all primary environments;
 - c. A medical assessment including a list of all medications including those specifically prescribed to modify challenging behaviors, the rationale for prescribing each medication, and the potential side effects of each medication;
 - d. A participant's history based upon the records and interviews with the participant and with the people important to/for the person (e.g. parents, caregivers, vocational staff, etc.);
 - e. Record reviews and interviews recording the history of the challenging behaviors and attempts to modify it;
 - f. Recommendations, after discussion of the results within the participant's interdisciplinary team, for strategies to be developed in a Behavior Plan; and
 - g. Development of the Behavior Plan.

B. Behavioral Consultation services include:

- 1. Recommendations for subsequent professional evaluation services (e.g., Psychiatric, Neurological, Psychopharmacological, etc.), not identified in the Behavioral Assessment, that are deemed necessary and pertinent to the behavioral challenges;
- 2. Consultation, subsequent to the development of the Behavioral Plan which may include speaking with the participant's Psychiatrists and other medical/therapeutic practitioners;
- 3. Developing, writing, presenting, and monitoring the strategies for working with the participant and his or her caregivers;
- 4. Providing ongoing education on recommendations, strategies, and next steps to the participant's support network (i.e. caregiver(s), family members, agency staff, etc.) regarding the structure of the current environment, activities, and ways to communicate with and support the participant;
- 5. Developing, presenting, and providing ongoing education on recommendations, strategies, and next steps to ensure that the participant is able to continue to participate in all pertinent environments (i.e. home, day program, job, and community) to optimize community inclusion;
- 6. Ongoing assessment of progress in all pertinent environments against identified goals;
- 7. Preparing written progress notes on the participant's goals identified in the Behavior Plan at a minimum include the following information:
 - a. Assessment of positive behavioral supports in the environment;
 - b. Progress notes detailing the specific Behavior Plan interventions and outcomes for the participant;
 - c. Data, trend analysis and graphs to detail progress on target behaviors identified in a Behavioral Plan; and
 - d. Recommendations;
- 8. Development and updates to the Behavioral Plan as required by regulations; and

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- 9. Monitoring and ongoing assessment of the implementation of the Behavioral Plan based on the following:
 - a. At least monthly for the first six months; and
 - b. At least quarterly after the first six months or as dictated by progress against identified goals.
- C. Brief Support Implementation Services includes:
 - 1. On-site execution and modeling of identified behavioral support strategies;
 - 2. Timely semi-structured written feedback to the clinicians on the provision and effectiveness of the Behavior Plan and strategies;
 - 3. Participation in on-site meetings or instructional sessions with the participant's support network regarding the recommendations, strategies, and next steps identified in the Behavior Plan;
 - 4. Brief Support Implementation Services cannot be duplicative of other services being provided (e.g. 1:1 supports); and
 - 5. The Brief Support Implementation Services staff is required to be onsite with the caregiver in order to model the implementation of identified strategies to be utilized in the Behavior Plan.
- D. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the participant's file.
- E. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.
- F. Behavioral Assessment is reimbursed based on a milestone for a completed assessment.

| G. The Behavior Pl | an is rein | nbursed base | d on a milestone | for a con | npleted plan | | | |
|--|--|---------------|------------------|-------------------------------------|---|---------|----------|-----------------------------|
| Specify applicable (i | if any) lin | nits on the a | mount, frequency | , or durat | ion of this s | ervice | : | |
| A. Behavioral AsseB. Behavioral Consineeds, supportin | sultation a | and Brief Su | • | ation Serv | vices service | hours | | ed on assessed |
| Service Delivery M (check each that app | | X Partici | pant-directed as | specified | in Appendi | х Е | X | Provider managed |
| Specify whether the service may be provided by (check each that applies): Legally Relative Relative Legal Guardian | | | | Guardian | | | | |
| | | | Provider Spec | ifications | | | | |
| Provider | X Individual. List types: | | X | Agency. List the types of agencies: | | | | |
| Category(s) (check one or | Qualified clinicians and staff for participant self-directing services | | | Lice | Licensed Behavioral Support Services Provider | | | |
| both): | | | | | | | | |
| | | | | | | | | |
| Provider Qualificat | tions | | | | | | | |
| Provider Type: | Licens | e (specify) | Certificate (s | pecify) | (| Other S | Standard | (specify) |
| Qualified clinicians and staff for | | | | | _ | | | omplete the nd consultation |

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participant self-

directing services

1. Licensed psychologist;

2. Psychology associate working under

| | | the license of the psychologist (and currently registered with and approved by the Maryland Board of Psychology); 3. Licensed professional counselor; 4. Licensed certified social worker; and 5. Licensed behavioral analyst. All clinicians must have training and experience in the following: 1. Applied Behavior Analysis; and 2. Behavioral Tiered Supports Plans Staff providing the Brief Support Implementation Services must be one of the following: 1. Registered Behavioral Technician, or 2. A person who has: a. Demonstrated completion of high school or equivalent/higher, b. Successfully completed an 40-hour Registered Behavioral Technician (RBT) training, and c. Receives ongoing supervision by a qualified clinician who meets the criteria to provided behavioral assessment and behavioral consultation. |
|--|--|---|
| Licensed Behavioral Support Services Provider | Licensed Behavioral Support Services Provider as per COMAR Chapter 10 Title 22 | Qualified clinicians to complete the behavioral assessment and consultation include: 1. Licensed psychologist; 2. Psychology associate working under the license of the psychologist (and currently registered with and approved by the Maryland Board of Psychology); 3. Licensed professional counselor; 4. Licensed certified social worker; and 5. Licensed behavioral analyst. All clinicians must have training and experience in the following: 1. Applied Behavior Analysis; and 2. Behavioral Tiered Supports Plans Staff providing the Brief Support Implementation Services must be one of |

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| | | | 2. A per a. D so b. S he T c. R qq cr | stered Behavioral Technician, or son who has: Demonstrated completion of high chool or equivalent/higher, uccessfully completed an 40-our Registered Behavioral Technician (RBT) training, and teceives ongoing supervision by a ualified clinician who meets the riteria to provided behavioral ssessment and behavioral consultation. |
|---|-------------------------------|--|---------------------------------------|---|
| Verification of Prov | ider Qualifications | | | |
| Provider Type: | Entity Re | Entity Responsible for Verification: | | Frequency of Verification |
| Individual for participant self-directing services | FMS provider, as | described in Appendix E | | FMS provider - prior to services |
| Licensed Behavioral Support Services Provider | Support Serv 2. Providers for | fication of Licensed Beha ices provider verification of clinician's ations and training | | DDA - annually Providers – prior to service delivery |

Service Type: Other

Service (Name): COMMUNITY DEVELOPMENT SUPPORTS

| Service Specification | | | | |
|----------------------------|------------------------------|--|--|--|
| HCBS Taxonomy | | | | |
| Category 1: | Sub-Category 1: | | | |
| 4: Day Habilitation | 04010 Prevocational Services | | | |
| Service Definition (Scope) | | | | |

- A. Community Development Services provide the participant with development and maintenance of skills related to community membership through engagement in community-based activities with people without disabilities.
 - 1. Community-based activities under this service will provide the participant with opportunities to develop skills and increase independence related to community integration with people without disabilities including:
 - a. Promoting positive growth and developing the skills and social supports necessary to gain, retain or advance competitive integrated employment opportunities;
 - b. Learning socially acceptable behavior; and
 - c. Learning self-advocacy skills.
- B. Community Development Services may include, but are not limited to, participation in the following

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activities:

- 1. Engagement in activities that facilitate and promote integration and inclusion of an individual into their chosen community; including identifying a path to employment for working age individuals;
- 2. Travel training;
- 3. Participating in self-advocacy classes and activities;
- 4. Participating in local community events; and
- 5. Volunteering within a non-profit organization whose mission the person supports.

C. Community Development Services include:

- 1. Support services that enable the participant to learn, develop, and maintain skills related to competitive employment, community integration, volunteer with an organization, or perform a paid or unpaid internship;
- 2. Transportation to, from, and within activities; and
- 3. Personal care assistance can be provided during community activities so long as it is not the primary or only service provided. Personal care assistance is defined as services to assist the participant in performance of activities of daily living and instrumental activities of daily living.

SERVICE REQUIREMENTS:

- A. Community Development Services can be provided in a variety of settings in the community.
- B. Community Development Services are separate and distinct from residential services. Participants may return home or to the provider operated site during time limited periods of the day to support personal care, health, emotional, and behavioral needs as indicated in the person-centered plan.
- C. Personal care assistance may not comprise the entirety of the service.
- D. A participant's person-centered plan may include a mix of employment and day related waiver services such as Day Habilitation, Transitional Employment Services, Employment Discovery and Customization, and Supported Employment provided at different times.
- E. Service may be provided in groups of no more than four (4) participants all of whom have similar interests and goals as outlined in his or her person-centered plan. The only exception is in the case of self-advocacy groups.
- F. Transportation to and from and within this service is included within the Community Development Services. Transportation will be provided or arranged by the licensed provider and funded through the rate system. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.
- G. An individualized schedule will be used to provide an estimate of what the individual will do and where the individual will spend their time when in this service. Updates should be made as needed to meet the changing needs, desires and circumstances of the individual. The individualized schedule will be based on a person-centered plan that clearly outlines how this time would be used.
- H. A relative (who is not a spouse or legally responsible person) of an individual recipient participating in Self-Directed Services may be paid to provide this service, provided however, the DDA pre-approves such payment in accordance with the applicable requirements set forth in Section C-2.
- I. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland's State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the individual's file.
- J. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

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| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | | | | | | | | | | |
|---|---|--------|-----------------------|------------|------------|---------|-------------|-------------------------------------|--|---|---|--|---|
| Community Development Services are limited to 40 hours per week. | | | | | | | | | | | | | |
| Service Delivery M (check each that app | | | | t-directed | as spe | ecified | in A | appendi | хE | X | | Provider managed | |
| Specify whether the be provided by (checapplies): | | - | | Res Per | | X | | Relative | | | Lega | l G | Guardian |
| | | | | | Provider S | Specifi | | | | | | | |
| Provider Category(s) | X | Ir | dividua | ıl. Lis | st types: | | X | Agency. List the types of agencies: | | | | | |
| (check one or both): | | | for Parti Services | icipa | nts Self- | | DDA Prov | | A Licensed Vocational or Day Service ider | | | | r Day Service |
| · | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| Provider Qualification | tions | | | | | | | 1 | | | | | |
| Provider Type: | Licen | ise (s | pecify) | - | Certificat | e (spe | cify) | | | Other S | standa | rd | (specify) |
| Individual for Participants Self- Directing Services | | | | | | | | 2. | require a. Cu ce b. Su ba of an pr c. Un tre M (M Te Partici as the additio on the such a on ind (include behave | ed: urrent f rtificat uccessf uckgrou her req d crede ovided nlicens edicatio eatment aryland (BON) echnicis ipants i employ onal sta ir prefe s traini ividual ding pr ior sup | First airion fully pund in uired ential in Aped sta on and ts must be as Mans. In self yer, maffing erenceing by l-spec peferer ports, | d a assive ba verbal ba verbal ba dicast la di | and CPR current s a criminal stigation and any ackground checks erifications as endix C-2-1a paid to administer or perform be certified by the of Nursing lication irecting services, require equirements based and level of needs adividual/family c information es, positive then needed, and formation) |
| DDA Licensed Vocational or Day Service Provider | DDA I Vocation Services per CO | onal o | or Day vider as | | | | | | inform | ined or nation (| inclu | din | -specific ng preferences, oports, when |

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| | Chapter 10 Title 22 | | inform 2. Posse licens requires service perso 3. Succes backgother crede | ed, and disability-specific mation); ess current appropriate ses/certifications and training as red by regulations based on see provided and needs of the n at time of service; and essfully pass a criminal ground investigation and any required background checks and ntial verifications as provided in ndix C-2-1a. | | |
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| | | | | | | |
| Verification of Pro | vider Qualifications | | | | | |
| Provider Type: | Entity F | Responsible for Verification | Frequency of Verification | | | |
| Individual for Participants Self- Directing Services | FMS provider, a | FMS provider, as described in Appendix E FMS provider - prior to service delivery | | | | |
| DDA Licensed Vocational or Day Service Provider | 2. Provider for | | | | | |

Service Type: Statutory

Service (Name): DAY HABILITATION

| Service Specification | | | | |
|-----------------------------|------------------------|--|--|--|
| HCBS Taxonomy | | | | |
| Category 1: | Sub-Category 1: | | | |
| 04: Day Services | 04020 Day Habilitation | | | |
| Service Definition (Scope): | | | | |

- A. Day Habilitation services provide the participant with development and maintenance of skills related to activities of daily living, instrumental activities of daily living, and vocation and socialization, through application of formal teaching methods and participation in meaningful activities.
 - 1. Teaching methods based on recognized best practices are used such as systematic instruction.
 - 2. Meaningful activities under this service will provide the participant with opportunities to develop skills related to the learning new skills, building positive social behavior and interpersonal skills, greater independence, and personal choice including, but not limited to:
 - a. Learning skills for employment

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- b. Learning socially acceptable behavior;
- c. Learning effective communication;
- d. Learning self-direction and problem solving;
- e. Engaging in safety practices;
- f. Performing household chores in a safe and effective manner; and
- g. Performing self-care.
- B. Day habilitation services may include, but are not limited to, participation in the following meaningful activities:
 - 1. Learning general skills that can be used to do the type of work the person is interested in;
 - 2. Participating in self-advocacy classes/activities;
 - 3. Participating in local and community events;
 - 4. Volunteering within a non-profit organization whose mission the person supports;
 - 5. Training and supports designed to maintain abilities and to prevent or slow loss of skills for individuals with declining conditions; and

Transportation services

- C. Day Habilitation Services include:
 - 1. Support services that enable the participant to participate in the activity;
 - 2. Transportation to, from, and within the activity; and
 - 3. Personal care assistance can be provided during day habilitation activities so long as it is not the primary or only service provided. Personal care assistance is defined as services to assist the participant in performance of activities of daily living and instrumental activities of daily living.

SERVICE REQUIREMENTS:

- A. Day Habilitation services can be provided in a variety of settings in the community or in a facility owned or operated by the provider agency.
- B. Day Habilitation services are separate and distinct from other waiver services, including residential services.
- C. A participant's person-centered plan may include a mix of employment and day related waiver services such as Supported Employment, Employment Discovery and Customization, Community Development Services, and Transitional Employment Services provided on different days.
- D. An individualized schedule will be used to provide an estimate of what the participant will do and where the participant will spend their time when in this service. Updates should be made as needed to meet the changing needs, desires and circumstances of the participant. The individualized schedule will be based on a person-centered plan.
- E. Transportation to and from and within this service is included within the Day Habilitation services.

 Transportation will be provided or arranged by the licensed provider and funded through the rate system.

 The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.
- F. Personal care assistance may not comprise the entirety of the service.
- G. Day Habilitation includes supports for volunteering and time limited paid and unpaid internships and apprenticeships.
- H. Day Habilitation does not include vocational services that: (1) teach job task specific skills required by a participant for the primary purpose of completing those tasks for a specific facility based job and (2) are delivered in an integrated work setting through employment supports.

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I. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland's State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the individual's file. J. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization. Specify applicable (if any) limits on the amount, frequency, or duration of this service: Day Habilitation services are provided Monday through Friday only. Day Habilitation services may not exceed a maximum of eight (8) hours per day (including other Supported Employment, Transitional Employment, Employment Discovery and Customization and Community Development Services). Participant-directed as specified in Appendix E X Provider **Service Delivery Method** (check each that applies): managed Legal Guardian Relative Specify whether the service may Legally be provided by (check each that Responsible applies): Person **Provider Specifications** Agency. List the types of agencies: Individual. List types: Provider Category(s) DDA Day Habilitation Service Provider (check one or both): **Provider Qualifications** Provider Type: License (specify) Certificate (specify) Other Standard (specify) Licensed DDA Day Staff must: DDA Day **Habilitation Service** 1. Be trained on person-specific Habilitation Provider as per information (including preferences, Service Provider COMAR Chapter positive behavior supports, when 10 Title 22 needed, and disability-specific information); 2. Possess current appropriate licenses/certifications and training as required by regulations based on service provided and needs of the person at time of service; and 3. Successfully pass a criminal background investigation and any other required background checks and credential verifications as provided in Appendix C-2-1a.

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| Verification of Provider Qualifications | | | | | |
|--|---|--|--|--|--|
| Provider Type: | Entity Responsible for Verification: | Frequency of Verification | | | |
| DDA Day Habilitation Service Provider | DDA for Provider's license to provide services Provider for individual staff member's licenses, certifications, and training | DDA – annual for license Provider – prior to service delivery and annually thereafter | | | |

Service Type: Other

Service (Name): EMPLOYMENT DISCOVERY AND CUSTOMIZATION

| Service Sp | pecification | |
|---------------------------|-----------------------|--|
| HCBS Taxonomy | | |
| Category 1: | Sub-Category 1: | |
| 03 Supported Employment | 03030 Career Planning | |
| Camina Dafinition (Coope) | | |

Service Definition (Scope):

- A. Employment Discovery and Customization services are time limited services to identify and develop customized employment options for individual working towards competitive integrated employment.
- B. Employment Discovery is a time-limited comprehensive, person-centered, community-based employment planning process. The Employment Discovery process and activities include:
 - 1. Visits to the individual's home;
 - 2. Assessment of the community surrounding their home;
 - 3. Work skills and interest inventory;
 - 4. Community-based job trials and community-based situations in order to identify skills, interest, and learning style;
 - 5. Identification of the ideal conditions for employment for the individual; and
 - 6. Development of an Employment Discovery Profile with all pertinent information about the individual's skills, job preferences, possible contributions to an employer, and useful social networks. The profile may also include a picture or written resume.
- C. Customization is support to assist an individual to obtain a negotiated competitive integrated job. The Customization process and activities include:
 - 1. The use of the individual's social network, community resources and relationships, the American Job's Centers, and provider business contacts to identify possible employers.
 - 2. Flexible strategies designed to assist in obtaining a negotiated competitive integrated job including: (a) job development, (b) job carving, (c) job sharing, (d) self-employment; and other national recognized best practices, based on the needs of both the job seeker and the business needs of the employer.

SERVICE REQUIREMENTS:

A. Employment Discovery and Customization services and supports are provided for individuals wanting to work in competitive integrated jobs paid by a private community employer.

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- B. A participant's person-centered plan may include a mix of employment and day related waiver services such as Day Habilitation, Community Development Services, Transitional Employment Services, and Supported Employment Services provided on different days.
- C. Transportation to and from and within this services in included within the Employment Discovery and Customization service. Transportation will be provided or arranged by the licensed provider and funded through the rate system. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.
- D. Employment Discovery and Customization services can also include personal care, behavioral supports, and delegated nursing tasks to support the activity.
- E. The participant may use a relative (as defined in Appendix C-2-e).
- F. A family member of an adult participant may not be paid for more than 40-hours per week of services.
- G. The program does not make payment to spouses or legally responsible individuals for providing Supported Employment services.
- H. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland's Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the individual's file.
- I. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.
- J. Documentation must be maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

| Spe | cify ap | plicable (i | if any) | limits on | the amount, | frequency | , or dura | tion of t | his service |
|-----|---------|-------------|---------|-----------|-------------|-----------|-----------|-----------|-------------|
|-----|---------|-------------|---------|-----------|-------------|-----------|-----------|-----------|-------------|

- A. Employment Discovery and Customization activities must be completed within a six (6) month period unless otherwise authorized by the DDA.
- B. Employment Discovery and Customization services are provided Monday through Friday only.
- C. Employment Discovery and Customization services may not exceed a maximum of eight (8) hours per day (including other Supported Employment, Transitional Employment Services, Community Development Services and Day Habilitation services).

| Service Delivery Method (check each that applies): A Participant-directed as s | | | | as spe | ecified in | Appendix | ĸЕ | X | Provider managed | |
|---|---|------|----------------------------------|-----------------|------------|------------------|--------|----------------|---------------------|----------------|
| Specify whether the service may be provided by (check each that applies): | | | Legally Responsible Person | | Relative | | | Legal Guardian | | |
| Provider Specific | | | | | cations | | | | | |
| Provider | X | Indi | ividua | ıl. List types: | | X | Agency | . List | the type | s of agencies: |
| Category(s) (check one or both): Individual for P Directing Service | | | | * | | DDA V Provide | | l or Su | pported | Employment |
| | | | | | | | | | | |
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| Provider Qualifica | tions | | | |
|---|---|--|---|--|
| Provider Type: | License (specify) | Certificate (specify) | | Other Standard (specify) |
| Individual for Participants Self- Directing Services | | | inform position needed inform 2. Possed licens required service person 3. Success backgother crede | st: ained on person-specific mation (including preferences, ive behavior supports, when ed and disability-specific mation); ess current appropriate ses/certifications and trainings, as red by regulations based on ce provided and needs of the on at time of service; and essfully pass a criminal ground investigation and any required background checks and ential verification as provided in endix C-2-1a. |
| DDA Vocational or Supported Employment Provider | Licensed DDA Vocational or Day Habilitation Service Provider as per COMAR Chapter 10 Title 22 | | inform position needer inform 2. Posser licens required service person 3. Succession other creder information of the position | st: ained on person-specific mation (including preferences, ive behavior supports, when ed and disability-specific mation); ess current appropriate ses/certifications and trainings, as red by regulations based on ce provided and needs of the en at time of service; and essfully pass a criminal ground investigation and any required background checks and ential verification as provided in endix C-2-1a. |
| Verification of Pro | vider Qualifications | | | |
| Provider Type: | | esponsible for Verificatio | | Frequency of Verification |
| Individual for Participants Self-Directing Services FMS provi | | s described in Appendix l | E | FMS provider - prior to service delivery |
| DDA Vocational or Supported Employment Provide | 2. Provider for | ovider's license to provide individual staff members tifications, and training | | DDA – annual for license Provider – prior to service delivery and annually thereafter |

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Service Type: Other Service

Service (Name):

Alternative Service Title: **ENVIRONMENTAL ASSESSMENT**

| Service Specification | | | | | |
|--|---|--|--|--|--|
| HCBS Taxonomy | | | | | |
| Category 1: | Sub-Category 1: | | | | |
| 14: Equipment, Technology, and Modifications | 14020 home and/or vehicle accessibility adaptations | | | | |
| Service Definition (Scope): | | | | | |

- A. An environmental assessment is an on-site assessment with the participant at his or her primary residence to determine if environmental modifications or assistive technology may be necessary in the participant's home.
- B. Environmental assessment includes:
 - 1. An evaluation of the participant;
 - 2. Environmental factors in the participant's home;
 - 3. The participant's ability to perform activities of daily living;
 - 4. The participant's strength, range of motion, and endurance;
 - 5. The participant's need for assistive technology and or modifications; and
 - 6. The participant's support network including family members' capacity to support independence.

SERVICE REQUIREMENTS:

- A. The assessment must be conducted by an Occupational Therapist licensed in the State of Maryland.
- B. The Occupational Therapist must complete an Environmental Assessment Service Report to document findings and recommendations based on an onsite environmental assessment of a home or residence (where the participant lives or will live) and interviews the participant and their support network (e.g. family, direct support staff, delegating nurse/nurse monitor, etc.).
 - The report shall:
 - 1. Detail the environmental assessment process, findings, and specify recommendations for the home modification and assistive technology that are recommended for the participant;
 - 2. Be typed; and
 - 3. Be completed with 10 business days of the completed assessment and forwarded to the participant and his or her Coordinator of Community Service (CCS) in an accessible format.
- C. An environmental assessment may not be provided before the effective date of the participant's eligibility for waiver services unless authorized by the DDA for an individual that is transitioning from an institution.
- D. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the participant's file.
- E. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Environment assessment is limited to one (1) assessment annually and is capped at current fiscal year established rate unless otherwise approved by the DDA

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| Service Delivery Method (check each that applies): | | | ipant-directed | as spe | ecified | in A | appendi | хЕ | X | Provider managed | |
|--|-------|----------------------------------|----------------|---|------------------------|--------|------------|--|---|--|---|
| provided by (check each that | | Legally Responsible Person | | | Relative [| | | Legal | Guardian | | |
| | | | | Provider Sp | ecifica | ations | | | | | |
| Provider Category(s) (check one or both): | X | Inc | dividua | l. List types: | | X | I | Agency | . List | the typ | es of agencies: |
| (check one or boin): | | | or Ven | dor– For Self- | | | | rtified (Provider | | ized He | alth Care Delivery |
| | | | | | | | | | | | |
| | | | | | | | | • | | | |
| Provider Qualificatio | | | | 1 | | | | | 7 | | |
| Provider Type: | Licer | ise (sp | ecify) | Certificate | e (spec | cify) | | Č | other S | Standard | l (specify) |
| Participant or Vendor– For Self- Directed Services | | | | | | | | Emplo Maryl Therap Occup or Contra | quired oy a st and B py Pra pations act wi pilitati | aff licer coard of actice as al Thera th a Div on Serv | mum standards nsed by the Occupational a licensed upist in Maryland vision of ices (DORS) |
| | | | | | | | 2. | as the | emplonal s | oyer, ma | directing services, ay require requirements erences. |
| DDA Certified Organized Health Care Delivery System Provider | | | | DDA certif Organized Care Delive Providers a COMAR T Subtitle 22 | Health ery s per | | OH ent qua | enses, confession ploys a milable used in the servathe March March March Cocupar or Contra | redentials wand had upon a must efforming no vice be on a carylar py Prabation act wi | tials, an ith who we a coprequest. Insure the second being proceed being proceed actice as al Therath a Div | d verify the d experience of all m they contract or by of the same the individual or ervice meets the own as applicable vided: staff licensed by d of Occupational a licensed apist in Maryland vision of ices (DORS) |

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| | ар | proved vendor | | | | |
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| Verification of Provider | Verification of Provider Qualifications | | | | | |
| Provider Type: | Entity Responsible for Verification: | Frequency of Verification | | | | |
| Participant or Vendor– For Self-Directed Services | 1. FMS provider, as described in Appendix E | FMS provider - prior to initial services | | | | |
| DDA Certified Organized Health Care Delivery System Provider | DDA for verification of the OHCDS certification OHCDS provider will verify Occupational Therapist (OT) license and DORS approved vendor | OHCDS certification annually OT license and DORS approved vendor prior to service delivery | | | | |

Service Type: Other Service

Service (Name):

Alternative Service Title: **ENVIRONMENTAL MODIFICATIONS**

| Service Sp | ecification |
|--|--|
| HCBS Taxonomy | |
| Category 1: | Sub-Category 1: |
| 14: Equipment, Technology, and Modifications | 14: Equipment, Technology, and Modifications |
| Service Definition (Scope): | |

- A. Environmental modifications are physical modifications to the participant's home based on an assessment designed to support the participant's efforts to function with greater independence or to create a safer, healthier environment.
- B. Environmental Modifications include but are not limited to:
 - 1. Installation of grab bars;
 - 2. Construction of access ramps and railings;
 - 3. Installation of detectable warnings on walking surfaces;
 - 4. Alerting devices for participant who has a hearing or sight impairment;
 - 5. Adaptations to the electrical, telephone, and lighting systems;
 - 6. Generator to support medical and health devices that require electricity;
 - 7. Widening of doorways and halls;
 - 8. Door openers;
 - 9. Installation of lifts and stair glides, such as overhead lift systems and vertical lifts;
 - 10. Bathroom modifications for accessibility and independence with self-care;
 - 11. Kitchens modifications for accessibility and independence;
 - 12. Alarms or locks on windows, doors, and fences; protective padding on walls, floors, or pipes; Plexiglas, safety glass, a protected glass coating on windows; outside gates and fences; brackets for appliances; raised/lowered electrical switches and sockets; and safety screen doors which are necessary for the health, welfare, and safety of the participant;
 - 13. Training on use of modification; and

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- 14. Service and maintenance of the modification.
- C. Not covered under this service are improvements to the home, such as carpeting, roof repair, decks, and central air conditioning, which:
 - (1) Are of general utility;
 - (2) Are not of direct medical or remedial benefit to the participant; or
 - (3) Add to the home's total square footage, unless the construction is necessary, reasonable, and directly related to accessibility needs of the participant.

SERVICE REQUIREMENTS:

- A. An environmental assessment must be completed by as per the environmental assessment waiver services requirements.
- B. All modifications \$2,000 or more must be pre-authorized by the DDA.
- C. If the modification is estimated to cost over \$2,000 over a 12-month period, at least three bids are required (unless otherwise approved by DDA).
- D. All modifications shall be pre-approved by the property manager or owner of the home, if not the participant, who agrees that the participant will be allowed to remain in the residence at least one year.
- E. When services are furnished to individuals returning to the community from a Medicaid institutional setting through entrance to the waiver, the costs of such services are considered to be incurred and billable when the individual leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition); services may be billed to Medicaid as an administrative cost.
- F. Environmental modifications services provided by a family member or relative are not covered.
- G. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- H. Not covered under this service is the purchase of a generator for general household appliances, washer/dryer, security systems, etc.
- I. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the participant's file. The DDA is the payer of last resort
- J. To the extent that any listed services are covered under the Medicaid State Plan, the services under the

| waiver would be limited consistent with waiver of | | | | | | the M | ledicaid | State Plan, but |
|--|---------|---------|--|--------|-----------------------|--------|----------|-----------------|
| Specify applicable (if any) l | imits c | n the a | amount, freque | ncy, o | or duration of this s | ervice | e: | |
| Cost of services must be customary, reasonable, and may not exceed a total of \$15,000 every five years, unless otherwise authorized by DDA. | | | | | | | | |
| Service Delivery Method (check each that applies): | X | Partic | Participant-directed as specified in Appendix E X Provider managed | | | | | |
| Specify whether the service may be provided by (check each that applies): Legally Relative Responsible Person | | | | | | | | Guardian |
| | | | Provider S | pecifi | cations | | | |

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| Provider | X | Individual. | List types: | X | Agency. List the types of agencies: | | | | |
| Category(s) (check one or | | | icipants in self- | | DA Certified Organized Health Care Delivery | | | | |
| both): | directed services | | System Provider | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| Provider Qualifica | | | T | | | | | | |
| Provider Type: | Licens | e (specify) | Certificate (spec | cify) | Other Standard (specify) | | | | |
| Individual – for participants in self-directed services | | | | | FMS must ensure the individual or entity performing the service meets the qualifications noted below and have a copy of the same available upon request: 1. Be licensed home contractors or Division of Rehabilitation Services (DORS) approved vendors; 2. All staff, contractors and subcontractors meet required qualifications including verify the licenses and credentials of all individuals whom the contractor employs or with whom the provider has a contract with and have a copy of same available for inspection; 3. Be in accordance with Department of Labor and Licensing requirements, a Home Improvement License may be required to complete some projects where an existing home structure is modified (such as a stair glide); and 4. All home contractors and subcontractors of services shall: a. Be properly licensed or certified by the State; b. Be in good standing with the Department of Assessment and Taxation to provide the service; c. Be bonded as is legally required; d. Obtain all required State and local permits; e. Obtain final required inspections; f. Perform all work in accordance with ADA, State and local building codes; g. Ensure that the work passes the required inspections including as performed in accordance with ADA, State and local building codes; and h. Provide services according to a written schedule indicating an | | | | |

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| | | | estimated start date and completion date and progress reports as indicated in the written schedule. |
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| Verification of Pro | ovider Qualifications | Agency must be a DDA certified Organized Health Care Delivery System Providers per COMAR Title 10, Subtitle 22. | oHCDS must ensure the individual or entity performing the service meets the qualifications noted below and have a copy of the same available upon request: 1. Be licensed home contractors or Division of Rehabilitation Services (DORS) approved vendors; 2. All staff, contractors and subcontractors meet required qualifications including verify the licenses and credentials of all individuals whom the contractor employs or with whom the provider has a contract with and have a copy of same available for inspection; 3. Be in accordance with Department of Labor and Licensing requirements, a Home Improvement License may be required to complete some projects where an existing home structure is modified (such as a stair glide); and 4. All home contractors and subcontractors of services shall: a. Be properly licensed or certified by the State; b. Be in good standing with the Department of Assessment and Taxation to provide the service; c. Be bonded as is legally required; d. Obtain all required State and local permits; e. Obtain final required inspections; f. Perform all work in accordance with ADA, State and local building codes; g. Ensure that the work passes the required inspections including as performed in accordance with ADA, State and local building codes; and h. Provide services according to a written schedule indicating an estimated start date and completion date and progress reports as indicated in the written schedule. |
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| Provider Type: | Entity Responsible for Verification: | Frequency of Verification |
|---|---|---|
| Individual – for participants in self-directed services | FMS providers, as described in Appendix E, for verification of participant specific qualifications | FMS provider - prior to service delivery and annually |
| DDA Certified Organized Health Care Delivery System Provider | DDA for verification of the OHCDS certification Organized Health Care Delivery System provider for verification of the contractors and subcontractors to meet required qualifications | OHCDS annually Contractors and subcontractors prior to service delivery |
| | | |

Service Type: Other

Service (Name): FAMILY AND PEER MENTORING SUPPORTS

| Service Specification | | | | | | | |
|-----------------------------|--|--|--|--|--|--|--|
| HCBS Taxonomy | | | | | | | |
| Category 1: | Sub-Category 1: | | | | | | |
| 9: Caregiver Support | 09020 caregiver counseling and/or training | | | | | | |
| Category 2: | Sub-Category 2: | | | | | | |
| 13: Participant Training | 13010 participant training | | | | | | |
| Service Definition (Scope): | | | | | | | |

- A. Family and Peer Mentoring Supports provide mentors who have shared experiences as the participant, family, or both participant and family and who provide support and guidance to the participant and his or her family members. Family and Peer mentors explain community services and programs and suggest strategies to the waiver participant and family to achieve the waiver participant's goals. It fosters connections and relationships which builds the resilience of the participant and his or her family.
- B. These services provide information, resources, guidance, and support from an experienced peer mentor, parent or other family member to a peer, another parent or family caregiver who is the primary unpaid support to the participant.
- C. Family and Peer Mentoring Supports services encourage participants and their family members to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through the waiver with other waiver participants and their families.

Service Requirements:

- A. Family and Peer Mentoring Supports provide support to the participant and his or her family in locating and accessing other community services and programs that may assist the participant to engage in community life.
- B. Family and Peer Mentoring Supports include supports to siblings from others with shared experiences.
- C. Family and Peer Mentoring Supports include facilitation of parent or family member "matches" and follow-up support to assure the matched relationship meets peer expectations.
- D. Family and Peer Mentoring Supports do not provide targeted case management services to a waiver participant; peer mentoring does not include determination of level of care, functional or financial eligibility

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| individual with of G. Mentors cannot A. Prior to accessing including but no Services ("DOR") | be an indevelopment or DDA to limited (S"), Sta | menton dividumenta their of funding d to the | ring are in the control of the contr | dentified in to developmentaties. Ily members. is service, all red by Marylat t of Education | other and M n, and | availa edicaid Depar | or the men ble and appr I State Plan, tment of Hu | nber of a ropriate , Division nan Re | fundir fon of Resource | Rehabilitation |
| explored and ex Specify applicable (| | | | | | | | | • | |
| speerly approache (| 11 4113) 1 | | on the un | iouni, iroquo | iie j , o | - Garac | ion or time o | ,cr ; rec. | | |
| Service Delivery M (check each that app | | X | Particip | oant-directed | as spe | cified | in Appendix | κE | X | Provider managed |
| Specify whether the be provided by (checapplies): | | | I | Legally Responsible Person | | Relati | | ו ם | Legal (| Guardian |
| Provider Category(s) | Provider Specificat X Individual. List types: | | | X | X Agency. List the types of agencies: | | | | | |
| (check one or both): | Individual for Participant Self- Directing Services | | | | | DDA Approved Family and Peer Mentoring Provider | | | | |
| , | | | | | | | | | | |
| Provider Qualificat | tions | | | | | | | | | |
| Provider Type: | Licen | ise (sp | ecify) | Certificate | e (spec | rify) | (| Other St | andard | (specify) |
| Individual for Participant Self- Directing Services | | | | | | | may be watangible de The follow required or children un 1. Be 2. Pa in record | agency ted expeaded and pare similar aived by emonstr ving min ne-to-or nder the e at leas ass a crin vestigat quired be edential ovided i | with 5 erience ent org service the Diation of minum ne interestage of tage of | 5 years c with self- anizations es. Experience DA with sufficient of skillset. staff standards are ractions with 5 18: |

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the operation of a vehicle is necessary to provide services; and

4. Have automobile insurance for all automobiles that are owned,

| | | | | eased, and/or hired and used in the rovision of care. |
|--|---------------------|--|--|---|
| DDA Approved Family and Peer Mentoring Provider | | | Mentoring demonstra advocacy delivering may be w tangible definition of the follow required of children with the following state of the f | proved Family and Peer g agency with 5 years ated experience with self-and parent organizations g similar services. Experience aived by the DDA with sufficient demonstration of skillset. wing minimum staff standards are one-to-one interactions with under the age of 18: e at least 18 years old; ass a criminal background exestigation and any other equired background checks and redentials verifications as rovided in Appendix C-2-a; cossess a valid driver's license, if the operation of a vehicle is ecessary to provide services; and lave automobiles that are owned, eased, and/or hired and used in the rovision of care. |
| Verification of Prov | ider Qualifications | | | |
| Provider Type: | | esponsible for Verification | | Frequency of Verification |
| Individual for Participant Self- Directing Services | | er, as described in Append | FMS provider - prior to service delivery | |
| DDA Approved Family and Peer Mentoring Provider 1. DDA for approval of Family and Peer Mentoring Provider or staff standard | | proval of Family and Peer staff standards | | DDA: Annually Provider: Prior to service delivery |

Service Type: Other

Service (Name): FAMILY CAREGIVER TRAINING AND EMPOWERMENT

SERVICES

| Service Specification | | | | | | |
|-----------------------|--|--|--|--|--|--|
| HCBS Taxonomy | | | | | | |
| Category 1: | Sub-Category 1: | | | | | |
| 9: Caregiver Support | 09020 caregiver counseling and/or training | | | | | |

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| COMMUNITY SUPPORTS WAIVER – Appendix C Page 30 of 70 | | | | | | | | | |
|---|--|--------|----------------------------------|---------|------------|------------|--------|----------|---------------------|
| Service Definition (Scope): | | | | | | | | | |
| A. Family Caregiver Training and Empowerment services provide education and support to the family caregiver of a participant that preserves the family unit and increases confidence, stamina and empowerment to support the participant. Education and training activities are based on the family/caregiver's unique needs and are specifically identified in the person-centered plan. B. This service includes educational materials, training programs, workshops and conferences, and transportation to and from training that help the family caregiver to: Understand the disability of the person supported; Achieve greater competence and confidence in providing supports; Develop and access community and other resources and supports; Develop or enhance key parenting strategies; Develop advocacy skills; Develop vocational skills when loss of job; and Support the person in developing self-advocacy skills. | | | | | | | | | |
| Service Requiremen | ts: | | | | | | | | |
| unpaid support, to living in the fami B. Prior to accessing including but not Services ("DORS explored and exh C. To the extent that be limited to addi | A. Family Caregiver Training and Empowerment is offered only for a family caregiver who is providing unpaid support, training, companionship, or supervision for a person participating in the waiver who is living in the family home. B. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the participant's file. C. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of avoiding institutionalization. | | | | | | | | |
| Specify applicable (if | any) limits on | the a | mount, frequen | icy, or | duration | of this se | ervice |): | |
| | | | | | | | | | |
| Service Delivery Me (check each that appl | | Partio | cipant-directed | as spe | ecified in | Appendi | хE | X | Provider managed |
| Specify whether the sprovided by (check edapplies): | | | Legally Responsible Person | | Relative | ; | | Legal | Guardian |
| | | | Provider Sp | ecific | ations | | | | |
| Provider | X Ind | ividua | l. List types: | | X | Agency | . List | the typ | es of agencies: |
| Category(s) (check one or both): | Individuals/I self-directing | | s – for participa ces | ants | DDA A | approved | Parer | nt Suppo | ort Agency |
| | | | | | | | | | |

| Provider Qualifications | | | | | | | | | | | |
|-------------------------|-------------------|-----------------------|------------------------------------|--|--|--|--|--|--|--|--|
| Provider Type: | License (specify) | Certificate (specify) | Other Standard (specify) | | | | | | | | |
| Individuals/Entities | | | DDA Approved Parent Support Agency | | | | | | | | |

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| for participantsself-directingservices | | | with dem- similar se | onstrated experience delivering ervices |
|--|------------------|-----------------------------|--|---|
| DDA Approved Parent Support Agency | | | proved Parent Support Agency onstrated experience delivering prvices | |
| Verification of Provide | r Qualifications | | | |
| Provider Type: | Entity Re | esponsible for Verification | n: | Frequency of Verification |
| Individuals/Entities – for participants self-directing services | FMS provider, as | s described in Appendix I | | Annually |
| DDA Approved Parent Support Agency | DDA for approva | ncies | Annually | |

Service Type: Other Service

Alternative Service Title: INDIVIDUAL AND FAMILY DIRECTED GOODS AND

SERVICES

| Service Specification | | | | | | | | |
|-----------------------------|--------------------------|--|--|--|--|--|--|--|
| HCBS Taxonomy | | | | | | | | |
| Category 1: | Sub-Category 1: | | | | | | | |
| 17: Other Services | 17010 goods and services | | | | | | | |
| Service Definition (Scope): | | | | | | | | |

- A. Individual and Family Directed Goods and Services are services, equipment, or supplies for self-directing participants that:
 - 1. Relate to a need or goal identified in the person-centered plan;
 - 2. Maintain or increase independence;
 - 3. Promote opportunities for community living and inclusion; and
 - 4. Not available under a waiver service or State Plan services.
- B. Individual and Family Directed Goods and Services decrease the need for Medicaid services, increase community integration, increase the participant's safety in the home, or support the family in the continued provision of care to the participant.
- C. The goods and services may include, but are not limited to: fitness memberships; fitness items that can be purchased at most retail stores; toothbrushes or electric toothbrushes; weight loss program services other than food; dental services recommended by a licensed dentist and not covered by health insurance; nutritional supplements recommended by a professional licensed in the relevant field; and fees for activities that promote community integration.
- D. Experimental or prohibited goods and treatments are excluded.
- E. Individual and Family Directed Goods and Services do not include services, goods, or items:
 - 1. Provided to or benefiting persons other than the member;
 - 2. Otherwise covered by the waiver or the Medicaid State Plan Services;
 - 3. Additional units or costs beyond the maximum allowable for any waiver service or Medicaid State Plan,

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- with the exception of a second wheelchair;
- 4. Co-payment for medical services, over-the-counter medications, or homeopathic services;
- 5. Items used solely for entertainment or recreational purposes, such as televisions, video recorders, game stations, DVD player, and monthly cable fees;
- 6. Monthly telephone fees;
- 7. Room & board, including deposits, rent, and mortgage expenses and payments;
- 8. Food;
- 9. Utility charges;
- 10. Fees associated with telecommunications;
- 11. Tobacco products, alcohol, or illegal drugs;
- 12. Vacation expenses;
- 13. Insurance; vehicle maintenance or any other transportation- related expenses;
- 14. Tickets and related cost to attend recreational events;
- 15. Personal trainers; spa treatments;
- 16. Goods or services with costs that significantly exceed community norms for the same or similar good or service:
- 17. Tuition; educational services otherwise available through a program funded under the Individuals with Disabilities Education Act (IDEA), including private tuition, Applied Behavior Analysis (ABA) in schools, school supplies, tutors, and home schooling activities and supplies;
- 18. Incentive payments and subsidies;
- 19. Subscriptions;
- 20. Training provided to paid caregivers;
- 21. Services in hospitals;
- 22. Costs of travel, meals, and overnight lodging for families and natural support network members to attend a training event or conference; or
- 23. Service animals and associated costs.

SERVICE REQUIREMENTS:

- A. Participant or the designated family member self-directing services on behalf of the participant make decisions on goods and services based on an identified need in the person-centered plan.
- B. Individual and Family Directed Goods and Services must meet the following requirements:
 - 1. The item or service would decrease the need for other Medicaid services; AND/OR
 - 2. Promote inclusion in the community; AND/OR
 - 3. Increase the participant's safety in the home environment; AND
 - 4. The participant does not have the funds to purchase the item or service or the item or service is not available through another source.
- C. Individual and Family Directed Goods and Services are purchased from the participant-directed budget and must be documented in the person-centered plan.
- D. Individual and Family Directed Goods and Services must be clearly noted and linked to an assessed participant need established in the person-centered plan.
- E. The goods and services must fit within the participant's budget without compromising the participant's health and safety.
- F. The goods and services must provide or direct an exclusive benefit to the participant.
- G. The goods and services provided are cost-effective (i.e., the service is available from any source, is least costly to the State, and reasonably meets the identified need) alternatives to standard waiver or State Plan services.
- H. The goods and services may not circumvent other restrictions on the claiming of FFP for waiver services, including the prohibition of claiming for the costs of room and board;

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| I. | I. Reimbursement shall be reasonable, customary, and necessary, as determined for the participant's needs and approved by DDA or its designee. | | | | | | | | | | |
|------|---|-------------------|---------------|----------|-------------------|-------|-----------|--------------|--------|-----------|-------------------|
| J. | •• | | | | | | | | | | |
| K. | To the extent that any listed services are covered under the State plan, the services under the waiver would | | | | | | | | | | |
| | be limited to add | | | | | d un | der the S | state plan, | but co | onsisten | nt with waiver |
| | objectives of avoiding institutionalization. | | | | | | | | | | |
| Spe | ecify applicable (i | f any) lin | nits on | the an | nount, frequenc | cy, o | duratio | n of this se | ervice | »: | |
| Ind | ividual Directed (| Goods an | d Servi | ices ar | e limited to \$5, | ,000 | per year | from the t | otal s | self-dire | ected budget. |
| | Service Delivery Method (check each that applies): Appendix E □ Provider managed □ Provider managed □ Provider managed □ □ Provider managed □ □ Provider managed □ □ □ □ □ □ □ □ □ | | | | | | | | | | |
| be j | Specify whether the service may be provided by (check each that applies): Legally Relative Degal Guardian Responsible Person | | | | | | | | | Guardian | |
| | | | | | Provider Spe | cific | | | | | |
| | vider egory(s) | X | Indiv | vidual. | List types: | | | Agency. | List | the type | es of agencies: |
| (ch | eck one or | Entity – services | _ | articipa | nts self-directi | ng | | | | | |
| bot | h): | SCIVICCS | , | | | | | | | | |
| | | | | | | | | | | | |
| Pro | ovider Qualificat | tions | | | | | | | | | |
| Pro | vider Type: | License | e (spec | eify) | Certificate (| spec | ify) | 0 | ther S | Standard | d (specify) |
| | ity – for | | | | | | | | | | |
| | ople self- ecting services | | | | | | | | | | |
| | rification of Prov | vider Qu | alifica | tions | | | | | | | |
| | Provider Type: | | $\overline{}$ | \ | esponsible for \ | Verit | fication: | T | Fr | eauenc | y of Verification |
| Ent | rity – for | FM | | | s described in A | | |] | | to purcl | |
| | ticipants self- | | | | | | | | | | |
| dire | ecting services | | | | | | | | | | |
| Se | ervice Type: Statu | utory | | | | | | | | | |
| Se | Service (Name): MEDICAL DAY CARE | | | | | | | | | | |
| | | | | | Service Spe | cific | ation | | | | |
| НС | BS Taxonomy | | | | | | | | | | |
| Cat | egory 1: | | | | | Sub- | -Categor | y 1: | | | |
| 1. T | 1. Day Services 04050 Adult Day Health | | | | | | | | | | |

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| Service Definition (S | Scope | e) : | | | | | | | | |
|--|---|--|----------------|----------------------------------|---------|-------------------|---------------------|---------|----------|--------------------|
| A. Medical Day Car | e (M | DC) is a m | edicall | ly supervised | day p | rogram. | | | | |
| B. Medical Day Car 1. Health care 2. Nursing servance of the | servivices rapy al the with a giene rvice servi | ces; ; services; rapy servic activities of ; s; ices Activit | es; f daily | living such a | s walk | ting, eat | ing, toileti | ng, gro | ooming, | and supervision of |
| Service Requirements: A. A participant must attend the Medical Day Care a minimum of four (4) hours per day for the service to be reimbursed. B. Medical Day Care services cannot be billed during the same period of time that the individual is receiving other day or employment waiver services. C. This waiver service is only provided to individuals age 21 and over. All medically necessary Medical Day Care services for children under age 21 are covered under the Medicaid State Plan pursuant to the EPSDT benefit. | | | | | | | | | | |
| Specify applicable (| if any |) limits on | the an | nount, freque | ncy, o | r durati | on of this s | service |): | |
| Service Delivery M (check each that app | | | Particip | pant-directed | as spe | cified in | n Appendiz | х Е | X | Provider managed |
| Specify whether the be provided by (checapplies): | servi | ice may |] | Legally Responsible Person | | Relativ | re | | Legal | Guardian |
| | | | | Provider S | pecific | | | | _ | _ |
| Provider Category(s) (check one or both): | | Indiv | vidual. | List types: | | X Medic | Agency al Day Ca | | | es of agencies: |
| | | | | | | | | | | |
| | Ц. | | | | | | | | | |
| Provider Qualificat | tions | | | 1 | | 1 | | | | |
| Provider Type: | Li | cense (spec | cify) | Certificate | e (spec | cify) | (| Other S | Standard | d (specify) |
| Medical Day Care Providers | | | | | | | | | | |
| Verification of Pro | vider | · Qualifica | tions | | | | | | | |
| Provider Type: Entity Responsible for Verification: Frequency of Verification | | | | | | y of Verification | | | | |

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Appendix C: 35

| Medical Day Care | Maryland Department of Health | Every 2 years and in response to |
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| Providers | | complaints |
| | | |

Service Type: Other

State:

Effective Date

Service (Name): PARTICIPANT EDUCATION, TRAINING AND ADVOCACY SUPPORTS

| Service Specification | | | | | | | | | |
|--|---|--|------------|---|---------|----------|--|--|--|
| HCBS Taxonomy | | | | ı | | — | | | |
| Category 1: | | | Sub | Sub-Category 1: | | | | | |
| 13: Participant Training | | | 130 | 13010 participant training | | | | | |
| Service Definition (Scope): | | | | | | | | | |
| A. Participant Education, Training and Advocacy Supports provides training programs, workshops and conferences that help the participant develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. B. Covered expenses include, but are not limited to: Enrollment fees, Books and other educational materials, and Transportation related to participation in training courses, conferences and other similar events. | | | | | | | | | |
| Service Requirements: A. Participant Education, Training and Advocacy Supports may include education and training for participants directly related to building or acquiring such skills. B. Support needs for education and training are identified in the participant's person-centered plan. C. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the participant's file. D. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of avoiding institutionalization. | | | | | | | | | |
| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | | | | | | |
| | | | | | | | | | |
| Service Delivery Method (check each that applies): Participant-directed as specified in Appendix E X Provider managed | | | | | | | | | |
| be provided by (check each that applies): Responsible Person | | | | | Legal (| Guardian | | | |
| D 11 | - | | Provider S | pecifi | | | | | |
| Provider Category(s) | X Individual. List types: | | | X Agency. List the types of agencies: | | | | | |
| (check one or | Individual for Participants Self- Directing Services | | | DDA Approved Participant Education, Training and Advocacy Supports Agency | | | | | |
| | | | | | | | | | |

| both): | | | | |
|---|----------------------|-------------------|------|---|
| | | | | |
| Provider Qualificat | tions | | | |
| Provider Type: | License (specify) | Certificate (spec | ify) | Other Standard (specify) |
| Individual for Participants Self- Directing Services | | | | DDA Approved Participant Education, Training and Advocacy Supports agency with demonstrated experience with delivering similar services. The following minimum staff standards are required for one-to-one interactions with children under the age of 18: 1. Be at least 18 years old; 2. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a; 3. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and 4. Have automobile insurance for all automobiles that are owned, leased, or hired and used in the provision of care. |
| DDA Approved Participant Education, Training and Advocacy Supports Agency | vider Qualifications | | | DDA Approved Participant Education, Training and Advocacy Supports agency with demonstrated experience with delivering similar services. The following minimum staff standards are required for one-to-one interactions with children under the age of 18: 1. Be at least 18 years old; 2. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a; 3. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and 4. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of care. |
| Verification of Pro | vider Qualifications | | | |

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| Provider Type: | Entity Responsible for Verification: | Frequency of Verification | | | |
|---|---|--|--|--|--|
| Individual for Participants Self- Directing Services | FMS provider, as described in Appendix E | FMS provider - prior to service delivery | | | |
| DDA Approved Participant Education, Training and Advocacy Supports Agency | DDA for approval of Family and Peer Mentoring Provider for staff standards | DDA: Annually Provider: Prior to service delivery | | | |

Service Type: Statutory Service Service (Name): Habilitation

Alternative Service Title: PERSONAL SUPPORTS

| Service Specification | | | | | | | |
|----------------------------|-------------------------------|--|--|--|--|--|--|
| HCBS Taxonomy | | | | | | | |
| Category 1: | Sub-Category 1: | | | | | | |
| 8: Home-Based Services | 08010 home-based habilitation | | | | | | |
| Service Definition (Scope) | | | | | | | |

Service Definition (Scope):

- A. Personal Supports are individualized supports, delivered in a personalized manner, to support independence in an individual's own home and community in which the participant wishes to be involved, based on their personal resources.
- B. Personal Supports services assist individuals who live in their own or family homes with acquiring and building the skills necessary to maximize their personal independence. These services include:
 - 1. In home skills development including but not limited to budgeting and money management; completing homework; maintaining a bedroom for a child or home for an adult; being a good tenant; cooking; personal care; house cleaning/chores; and laundry;
 - 2. Community integration and engagement skills development needed to be part of a family event or community at large. Community integration services facilitate the process by which individuals integrate, engage and navigate their lives at home and in the community. They may include, but are not limited to the development of skills or providing supports that make it possible for individuals and families to lead full integrated lives (e.g. grocery shopping; getting a haircut; using public transportation; attending school or social events; joining community organizations or clubs; any form of recreation or leisure activity; volunteering; and participating in organized worship or spiritual activities); and
 - 3. Personal care assistance services during in-home skills development and community activities. Personal care assistance services include assistance with activities of daily living and instrumental activities of daily living, which may include meal preparation and cleaning when the person is unable to do for themselves only when in combination of other allowable Personal Supports activities occurring.

SERVICE REQUIREMENTS:

- A. Personal Supports services under the waiver differ in scope, nature, and provider training and qualifications from personal care services in the State Plan.
- B. Personal Supports are available:
 - 1. Before and after school,
 - 2. Any time when school is not in session,

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- 3. Before and after meaningful day services, and
- 4. On nights and weekends.
- C. Under self-directing services, the following applies:
 - 1. Participant or parent of a child self-directing services are considered the employer of record;
 - 2. Participant or parent of a child is responsible for supervising, training, and determining the frequency of services and supervision of their direct service workers; and
 - 3. Payment is allowable for advertising for employees and staff training
 - a. Costs are incurred no more than 180 days in advance of waiver enrollment unless otherwise authorized by the DDA
 - b. Costs are considered to be incurred and billable when the individual enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition); these costs may be billed to Medicaid as an administrative cost.
- D. Transportation costs associated with the provision of services outside the participant's home is covered within the rate.
- E. Personal care assistance services must be provided in combination with home skills development or community integration and engagement skills development and may not comprise the entirety of the service.
- F. A relative (who is not a spouse or legally responsible person) of a participant may be paid to provide this service in accordance with the applicable requirements set forth in Section C-2. The program does not make payment to spouses or legally responsible individuals, including legally responsible adults of children and representative payee, for supports or similar services.
- G. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the participant's file.
- H. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | | | | | | | |
|---|--|--|----------|----------|-------------------------------------|----------------|-------------------------------------|--|--|--------------|
| A. A relative of an adult participant may not be paid for greater than 40-hours per week for services rendered to any Medicaid participant at the service site, unless otherwise approved by the DDA. | | | | | | | | | | |
| Service Delivery Method (check each applies): | Method (check each that managed | | | | | | | | | |
| Specify whether the service may be provided by (check each that applies): Legally Responsible Person | | | Relative | | | Legal Guardian | | | | |
| | | | | Provider | Speci | fications | | | | |
| Provider | X Individual. List types: | | | | | X | Agency. List the types of agencies: | | | of agencies: |
| Category(s) (check one or both): | For participants self-directing services | | | | Licensed Personal Supports Provider | | | | | |
| <i>bom</i> ;• | | | | | | | | | | |
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| Provider Qualifications | | | | | | | | | | |

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| Provider Type: | License (specify) | Certificate (specify) | Other Standard (specify) |
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| Individual for participants self-directing services | | | The following minimum standards are required: a. Be at least 18 years old; b. Current first aid and CPR certification; c. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a; d. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians; e. Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; and f. Have automobile insurance for all automobiles that are owned, leased, or hired and used in the provision of care. Participants in self-directing services, as the employer, may require additional staffing requirements based on their preferences and level of needs such as: a. Training by participant/family on participant-specific information (including preferences, positive behavior supports, when needed, and disability-specific information) and b. Previous experience with in home skills such as training on money management, time management and community resources. |
| Licensed Personal Support Provider | Licensed Personal Supports Provider as per COMAR Chapter 10 Title 22 | | The following minimum staff standards are required: Be at least 18 years old; Be trained on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information); Possess current appropriate licenses/certifications and training as |

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| Varification of Provid | or Qualifications | | proof: 4. Sudinv bac ver 2; 5. Un me mu of 1. Tec 6. Pos ope pro 7. Ha aut and car 8. Sta ma con per proof per proof per | Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians; Possess a valid driver's license, if the operation of a vehicle is necessary to provide services; Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of care; and Staff providing training on money management, time management and community resources must have performed training on these topics in the previous two (2) years. Frequency of Verification | | | | |
|--|-------------------|--|--|--|--|--|--|--|
| Verification of Provider Qualifications Provider Type: Entity Responsible for Verification: Frequency of Verification | | | | | | | | |
| Individual for people Fiscal Management Service (FMS) providers, as FMS pro | | | FMS provider - prior to service delivery | | | | | |
| Licensed Personal Support Provider 1. DDA for verification of provider license 2. Provider for staff licenses, certifications, and training 2. Provider – prior to service delivery | | | | 2. Provider – prior to service | | | | |

Service Type: Statutory

Service (Name): **RESPITE CARE SERVICES**

| Service Specification | | | | | |
|-----------------------|----------------------------|--|--|--|--|
| HCBS Taxonomy | | | | | |
| Category 1: | Sub-Category 1: | | | | |
| 9: Caregiver Support | 09011 respite, out-of-home | | | | |
| Category 2: | Sub-Category 2: | | | | |

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| 0. | Caregiver Support | iver Support 09012 respite, in-home | | | | | | | | |
|---|--|-------------------------------------|---------|-----------------|--------|---------------------|--------|------|---------|---------------------|
| | | | | | | | | | | |
| Sei | Service Definition (Scope): | | | | | | | | | |
| | The home of a respite care provider, A licensed residential site, State certified overnight or youth camps, and | | | | | | | | | |
| SE | RVICE REQUIREMEN | ·2T | | | | | | | | |
| | Someone who lives wit who normally provides funded service to the pa | th the p | or the | | | | | | | |
| B. | A relative (who is not a be paid to provide this sapplicable requirements | spous service | e or le | ever, the DDA | must | | | | | |
| C. | The individual or the fa Appendix C-2-e). | | | | | dividual lives may | use a | rela | tive (a | s defined in |
| D. | | ay pro | vide s | ervices under t | he sai | me requirements (a | s defi | ned | in Ap | pendix C-2-e). |
| | D. A neighbor or friend may provide services under the same requirements (as defined in Appendix C-2-e). E. The program does not make payment to spouses or legally responsible individuals for providing respite services. | | | | | | | | | |
| | F. Receipt of respite services does not preclude a participant from receiving other services on the same day. For example, the participant may receive day services on the same day they receive respite services. | | | | | | | | | |
| | Payment rates for service | | | | | | | | | |
| | Services can be provide | | | • | | _ | | ov | er 8 ho | ours, daily. |
| I. J. | Respite cannot replace of respite is provided in home of a relative paid | a priva | ate ho | me, the home | | | | ne p | articip | oant's home or the |
| K. | home of a relative, neighbor, or friend. K. Respite does not include funding for any fees associated with the respite care (for example, membership fees at a recreational facility, community activities, or insurance fees). | | | | | | | | | |
| L. | L. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be | | | | | | | | | |
| M. | explored and exhausted. These efforts must be documented in the participant's file. M. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but | | | | | | | | | |
| consistent with waiver objectives of avoiding institutionalization. | | | | | | | | | | |
| Spo | ecify applicable (if any) | limits o | on the | amount, frequ | ency, | or duration of this | servi | e: | | |
| | | | | | | | | | | |
| Μe | ethod (check each that | X | Partic | ipant-directed | as sp | ecified in Appendi | х Е | | X | Provider managed |
| | olies): | | | · | ** | D 1 | | L | | 1. |
| | ecify whether the service provided by <i>(check each</i> | | | | | | | | | |

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| applies): | | I | Person | | | | | |
|---|--|-------------|---------------|-----------|---|---|--|--|
| | | Provider | Specific | cation | ons | | | |
| Provider | X Individual. | | . List types: | | X | Agency. List the types of agencies: | | |
| Category(s) (check one or both): | For participants self-directing services | | | | Licensed Community Residential Services Provider | | | |
| <i>bom)</i> • | | | | | DDA Approved Respite Care Provider | | | |
| | | | | | | | | |
| Provider Qualifica | ations | | | | | | | |
| Provider Type: | Licens | e (specify) | Certificat | e (specif | fy) | Other Standard (specify) | | |
| For participants self-directing services - | | | | | | The following minimum standards are required: Current first aid and CPR certification, unless waived by the participant or their family; Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a; Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians; and Camps including: | | |
| Licensed Community Residential Services Provider | as per C | nity | | | | Direct care staff specific requirements include the following: a. Current first aid and CPR training and certification, unless waived by the participant or their family; b. Training by participant/family on participant-specific information | | |

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| | | | (including preferences, positive behavior supports, when needed, and disability-specific information); c. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a; d. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians; and e. Additional requirements based on the participant's preferences and level of needs. |
|--|--|-------|--|
| | | 2. | Camps requirements including: a. State certified overnight or youth camps, as per COMAR 10.16.06, unless otherwise approved by the DDA; and b. DDA approved camp. Services provided in a site must be licensed. |
| DDA Approved Respite Care Provider | | 1. 2. | DDA Approved Respite Care Services Provider Direct support staff specific requirements include the following: a. Current first aid and CPR training and certification, unless waived by the participant or their family; b. Training by participant/family on participant-specific information (including preferences, positive behavior supports, when needed, and disability-specific information); c. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a; d. Unlicensed staff paid to administer |

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| Verification of Provide | e. A t 3. Cam a. Sta car oth b. DE 4. Serv be li by th | medication and/or perform reatments must be certified by the Maryland Board of Nursing (MBON) as Medication (Technicians; and Additional requirements based on he participant's preferences and evel of needs. ps requirements including: the certified overnight or youth mps as per COMAR 10.16.06 unless erwise approved by the DDA; and DA approved camp ices provided in a provider site must censed unless otherwise approved the DDA | |
|--|--|--|--|
| Provider Type: Entity Responsible for Verification: Frequency of Verific | | | |
| For participants self-directing services | THE STATE OF THE S | | |
| Licensed Community Residential Services Provider | DDA for verification of provider license and licensed site Licensed Community Residential Services Provider for verification of direct support staff and camps DDA - annually Licensed Community Residential Services Provider – prior to service delivery | | |
| DDA Approved Respite Care Provider | DDA for verification of provider and licensed site DDA Approved Respite Care Services Provider for verification of direct support staff and camps DDA - annually DDA Approved Respite Care Services Services Provider – prior to service delivery | | |

Service Type: Support for Participant Direction

Service (Name): **SUPPORT BROKER SERVICES**

| Service Specification | | | | | |
|---------------------------------------|---|--|--|--|--|
| HCBS Taxonomy | | | | | |
| Category 1: | Sub-Category 1: | | | | |
| 12 Services Supporting Self-Direction | 12020 Information and assistance in support of self-direction | | | | |
| Service Definition (Scope): | | | | | |
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- A. Support Broker Services are employer related information and assistance for a participant in support of self-direction to make informed decisions related to day-to-day management of their services and budget.
- B. Information may be provided to participant about:
 - 1. Self-direction including roles and responsibilities and functioning as the common law employer;
 - 2. Other subjects pertinent to the participant and/or family in managing and directing services;
 - 3. The process for changing the person centered plan and individual budget;
 - 4. The grievance/complaint process;
 - 5. Risks and responsibilities of self-direction;
 - 6. Policy on Reportable Incidents and Investigations (PORII);
 - 7. Free choice of staff/employees;
 - 8. Individual rights; and
 - 9. The reassessments and review of work schedules.
- C. Assistance, if chosen by the participant, may be provided with:
 - 1. Initial planning and start-up activities;
 - 2. Practical skills training (e.g., hiring, managing and terminating workers, problem solving, conflict resolution);
 - 3. Development of risk management agreements;
 - 4. Development of an emergency back-up plan;
 - 5. Recognizing and reporting critical events;
 - 6. Independent advocacy, to assist in filing grievances and complaints when necessary;
 - 7. Recruiting, interviewing, and hiring staff;
 - 8. Staff supervision and evaluation;
 - 9. Firing staff;
 - 10. Participant direction including risk assessment, planning, and remediation activities;
 - 11. Managing the budget and budget modifications including reviewing employee timesheets and monthly Fiscal Management Services reports to ensure that the individualized budget is being spent in accordance with the approved person centered plan and budget and conducting audits;
 - 12. Managing employees, supports and services;
 - 13. Facilitating meetings and trainings with employees;
 - 14. Employer development activities;
 - 15. Employment quality assurance activities;
 - 16. Developing and reviewing data, employee timesheets, and communication logs;
 - 17. Development and maintenance of effective back-up and emergency plans;
 - 18. Training all of the participant's employees on the Policy on Reportable Incidents and ensuring that all critical incidents are reported to the Office of Health Care Quality and DDA;
 - 19. Complying with all applicable regulations and policies, as well as standards for self-direction including staffing requirements and limitations as required by the DDA; and
 - 20. Assisting with developing relationships between the employer, participant and family

SERVICE REQUIREMENTS:

- A. Participants may utilize a family member with the exception of spouses, legally responsible adults (i.e. parents of children), and legal representative payee.
- B. Spouses and legally responsible adults (i.e. parents of children) may act only as unpaid support brokers.
- C. A relative (who is not a spouse or legally responsible person) of an individual recipient participating in Self-Directed Services may be paid to provide this service, provided however, the DDA pre-approves such payment in accordance with the applicable requirements set forth in Section C-2.
- D. Support Brokers, including family members, must provide assurances that they will implement the -Person Centered Plan as approved by DDA or their designee in accordance with all federal and state laws and regulations governing Medicaid, including the maintenance of all employment and financial records including timesheets and service delivery documentation.
- E. Individuals and organizations providing Support Brokerage services may provide no other paid service to

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| that individual. F. Support Brokerage services may not duplicate, replace, or supplant Coordination of Community Service. G. Scope and duration of support brokerage services may vary depending on the participant's choice and need for support, assistance, or existing netural supports. | | | | | | | | |
|--|---|---------|-----------|---|---|---|--|--|
| for support, assistance, or existing natural supports. H. Service hours must be necessary, documented, and evaluated by the team. | | | | | | | | |
| Specify applicable (| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | | | | |
| | | | | | | | | |
| Service Delivery M (check each that app | | X | Particip | pant-directed as spe | ecified | in Appendix E Provider managed | | |
| Specify whether the be provided by (checapplies): | | • | I | Legally X Responsible Person | egally X Relative Legal Guardian esponsible | | | |
| Provider Cotonomics | X | Inc | dividual. | Provider Specific List types: | cations X | Agency. List the types of agencies: | | |
| Category(s) (check one or both): | Individual for Participants Self- Directing Services | | | ipants Self- | Certified Support Broker Agency | | | |
| | | | | | | | | |
| | | | | | | | | |
| Provider Qualificat | | | • • • • • | G IS | 10.) | | | |
| Provider Type: | Licen | ise (sp | pecify) | Certificate (spec | cify) | Other Standard (specify) | | |
| Individual for Participants Self-Directing Services | | | | Certified by the It to demonstrate competency relate self-determination consumer directed services and services and services and services (generic government-sponsored) for individuals with disabilities and effective staff management strategies. | ore ed to n, d ice | Support Broker must: Comply with all training as required by the DDA including the Policy on Reportable Incidents and Investigations (PORII) and Support Broker trainings. Successfully pass a criminal background investigation and any other required background checks and credential verifications as provided in Appendix C-2-1a. Be trained by individual/family on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information). Maintain current DDA Support Broker certification. Individuals in self-directing services, as the employer, may require additional staffing requirements based on their preferences and level of needs | | |

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| Certified Support Broker Agency | services and service systems (generic and government- sponsored) for individuals with disabilities and effective staff management strategies | Compthe DI Report Invest Broke Succe backg other creder Apper Be trapersor prefer suppospecif Maint | roker must: ly with all training as required by DA including the Policy on table Incidents and igations (PORII) and Support or trainings. ssfully pass a criminal round investigation and any required background checks and intial verifications as provided in indix C-2-1a. ined by individual/family on in-specific information (including ences, positive behavior rts, when needed, and disabilitytic information). ain current DDA Support Broker cation. |
|--|--|--|--|
| Verification of Provide | er Qualifications | | · |
| Provider Type: | Entity Responsible for Verification | 1: | Frequency of Verification |
| Individual for Participants Self- Directing Services | | | FMS provider - prior to service |
| Certified Support Broker Agency | FMS provider, as described in Append Certified Support Broker Agency for individual staff members' certification training | | FMS provider - prior to service delivery Provider - prior to service delivery and annually thereafter |

Service Type: Statutory

Service (Name): **SUPPORTED EMPLOYMENT**

| Service Specification | | | | |
|--|--|--|--|--|
| HCBS Taxonomy | | | | |
| Category 1: | Sub-Category 1: | | | |
| 03 Supported Employment | 03010 Job development | | | |
| | 03021 Ongoing supported employment, individual | | | |
| | 03030 Career planning | | | |
| Service Definition (Scope): | | | | |
| A. Supported Employment services include a variety of supports to help an individual identify career and employment interest, as well as to find and keep a job. | | | | |

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- B. Supported Employment activities include:
 - 1. Individualized job development and placement;
 - 2. On-the-job training in work and work-related skills;
 - 3. Facilitation of natural supports in the workplace;
 - 4. Ongoing support and monitoring of the individual's performance on the job;
 - 5. Training in related skills needed to obtain and retain employment such as using community resources and public transportation;
 - 6. Negotiation with prospective employers; and
 - 7. Self-employment supports.

Supported Employment services include:

- 1. Support services that enable the participant to gain competitive integrated employment;
- 2. Transportation to, from, and within the activity; and
- 3. Personal care assistance can be provided during supported employment activities so long as it is not the primary or only service provided. Personal care assistance is defined as services to assist the participant in performance of activities of daily living and instrumental activities of daily living.

SERVICE REQUIREMENTS:

- A. Services and supports are provided for individuals in finding and keeping jobs paid by a community employer.
- B. Individual must be engaged in Supported Employment activities a minimum of four hours per day.
- C. A participant's person-centered plan may include a mix of employment and day related waiver services such as Day Habilitation, Community Development Services, Transitional Employment Services, and Employment Discovery and Customization provided on different days.
- D. Supported Employment services does not include:
 - 1. Volunteering, apprenticeships, or internships unless it is part of the discovery process and time limited; and
 - 2. Payment for supervision, training, supports and adaptations typically available to other workers without disabilities filling similar positions.
- E. Supported Employment does not include payment for supervision, training, supports and adaptations typically available to other workers without disabilities filling similar positions.
- F. Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.
- G. Under the traditional service model, transportation to and from and within this service is included within the Supported Employment Services. Transportation will be provided or arranged by the licensed provider and funded through the rate system. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.
- H. Supported Employment services can also include personal care, behavioral supports, and delegated nursing tasks to support the employment activity.
- I. The participant may use a relative (as defined in Appendix C-2-e).
- J. A family member of an adult participant may not be paid for more than 40-hours per week of services.
- K. The program does not make payment to spouses or legally responsible individuals for providing Supported Employment services.
- L. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland's Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the individual's file.
- M. Documentation must be maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20

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| U.S.C. 1401 et seq.). | | | | | | | | | | |
|---|---|---|---|--|---|--|--|--|--|--|
| Specify applicable (if any) limits on the amount, frequency, or duration of this service: | | | | | | | | | | |
| | | | | | | | | | | |
| e Delivery Method each that applies): Participant-directed as specified in Appendix E X Provider managed | | | | | | | | | | |
| ne service may heck each that Legally Responsible Person | | | | Relati | | | | | | |
| Y | In | dividual | | pecifi | | | | | | |
| Individ | dual f | or Partic | | | | X Agency. List the types of agencies: DDA Supported Employment Provider | | | | |
| | | | | | | | | | | |
| | | | | | Ц_ | | | | | |
| | | | <u> </u> | | | | | | | |
| Licen | se (sp | ecify) | Certificate | e (spec | cify) | Other Standard (specify) | | | | |
| | | | | | | The following minimum standards are required: Current first aid and CPR certification, and Passing a criminal background investigation and any other required background checks and credential verifications as provided in Appendix C-2-1a. Unlicensed staff paid to administer medication and/or perform treatments must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians. Individuals in self-directing services, as the employer, may require additional staffing requirements based on their preferences and level of needs such as: DDA approved certification in discovery, customized employment, and job development; and Training by individual/family on | | | | |
| | ethod lies): service k each X Individuolised | f any) limits of thod X lies): Service may k each that X Individual f Directing Service Service may | thod X Participlies): Service may k each that X Individual Individual for Participlies Services | fany) limits on the amount, frequence thod X Participant-directed lies): Service may Responsible Person Provider S X Individual. List types: Individual for Participants Self-Directing Services | thod X Participant-directed as specifies): Service may k each that | Fany) limits on the amount, frequency, or durated as specified lies): Service may Legally X Related Responsible Person Provider Specification X Individual for Participants Self-Directing Services DDA Directing Services DDA DIRECTION DIREC | | | | |

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| | | and disability-specific information). | | | |
|--|---|---|--|--|--|
| DDA Supported Employment Provider | Licensed DDA Supported Employment Provider as per COMAR Chapter 10 Title 22 | | Staff must: 1. Be trained on person-specific information (including preferences, positive behavior supports, when needed, and disability-specific information); 2. Possess current appropriate licenses/certifications and trainings, a required by regulations based on service provided and needs of the person at time of service, and 3. Successfully pass a criminal background investigation and any other required background checks an credential verifications as provided in Appendix C-2-1a. | | |
| Verification of Pro- | vider Qualifications | | | | |
| Provider Type: | Entity R | esponsible for Verification | n: | Frequency of Verification | |
| Individual for Participants Self- Directing Services | FMS provider, a | s described in Appendix E | | FMS provider - prior to service delivery | |
| Licensed Supported Employment Providen | ler service 2. Provider for | ovider's license to provide individual staff members' tifications, and training | | DDA – annual for license Provider – prior to service delivery and annually thereafter | |

Service Type: Statutory

Service (Name): TRANSITIONAL EMPLOYMENT SERVICES

| Service Sp | ecification |
|-----------------------------|---|
| HCBS Taxonomy | |
| Category 1: | Sub-Category 1: |
| 03 Supported Employment | 03022 Ongoing supported employment, group |
| Service Definition (Scope): | |
| | |

- A. Transitional Employment Services are time limited services to help individuals learn skills to work in competitive integrated employment.
 - 1. Teaching methods based on recognized best practices are used such as systematic instruction.
 - 2. Transitional Employment services provide the participant with opportunities to develop skills related to

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work in a competitive employment position in an integrated community environment including, but not limited to, learning:

- a. skills for employment, such as time-management and strategies for completing work tasks;
- b. socially acceptable behavior in a work environment;
- c. effective communication in a work environment; and
- d. self-direction and problem-solving for a work task.
- B. Transitional Employment Services includes (1) Facility-Based Employment Supports; (2) Small Group Employment Supports; and (3) Large Group Employment Supports.
- 1. Facility-Based Employment Supports are provided at a fixed site that is owned, operated, or controlled by a licensed provider.
 - 2. Small Group Employment Supports are provided in groups of between two (2) and eight (8) individuals (including the participant) where the group completes work tasks on a contract-basis. This work must be conducted at another site in the community not owned, operated, or controlled by the licensed provider. The licensed provider is the employer of record and enters into the contract, including enclaves, mobile work crews, and contract work, on behalf of the group.
 - 3. Large Group Employment Supports are provided in groups of between nine (9) and sixteen (16) individuals (including the participant) where the group completes work tasks on a contract-basis. This work must be conducted at another site in the community not owned, operated, or controlled by the licensed provider. The licensed provider is the employer of record and enters into the contract on behalf of the group.

SERVICE REQUIREMENTS

- A. Transitional Employment Services and supports must be provided in compliance with all applicable federal, State, and local laws and regulations.
- B. Participants must have an employment goal within their person-centered plan that outlines how they will transition to community integrated employment (such as participating in discovery and job development).
- C. A participant's person-centered plan may include a mix of employment and day type services such as Day Habilitation, Community Development Services, Employment Supports provided on different days.
- D. Transportation to and from and within this service is included within the Transitional Employment Services. Transportation will be provided or arranged by the licensed provider and funded through the rate system. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when appropriate.
- E. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland's Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the individual's file.
- F. To the extent any listed services are covered under the Medicaid State Plan, the services under the waiver will be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transitional Employment Services – Facility Based Employment Services are provided Monday through Friday only.

Transitional Employment services may not exceed a maximum of eight (8) hours per day (including other Community Development, Employment Discovery and Customization, and Day Habilitation services).

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| Transitional Employment Services are limited to 40 hours per week. | | | | | | | | | | |
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| Service Delivery M (check each that app | | | | | | | Provider managed | | | |
| Specify whether the be provided by (che applies): | | | I | Legally Responsible Person Provider S | Relative | | | Legal (| Guardian | |
| Provider | | Indi | vidual. | List types: | респи | X | | | | |
| Category(s) (check one or both): | | Indi | · rauur. | Dist types. | | | | l or Supported Employment | | |
| , | | | | | | | | | | |
| D '1 O 1'0' | 4. | | | | | | • | | | |
| Provider Qualifica Provider Type: | | | | | (specify) | | | | | |
| * * | License (specify) Licensed DDA | | | Certificate (specify) | | | Other Standard (specify) Staff must: | | | |
| DDA Vocational or Supported Employment Provider | Vocatio Support Employ Provide COMA 10 Title | onal or ted ment or as pe R Chap | or ent s per Chapter | | | | Be trainform positineede inform Posse licens require service person Succeeded backgoother credet | nation (ve beha ed, and c mation); ss curre es/certifed by r ee provide n at time essfully ground is required | includition support appropriate appropriat | n-specific ng preferences, pports, when ry-specific opriate as and trainings, as ons based on I needs of the vice; and criminal ation and any ground checks and ons as provided in |
| Verification of Pro | Verification of Provider Qualifications | | | | | | | | | |
| Provider Type: Licensed Supported Employment Provid | | | | | nnual for license – prior to service and annually | | | | | |

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Service Type: Other Service

Alternative Service Title: **TRANSPORTATION**

| Service Specification | | | | | |
|--------------------------------|----------------------------------|--|--|--|--|
| HCBS Taxonomy | | | | | |
| Category 1: | Sub-Category 1: | | | | |
| 15: Non-Medical Transportation | 15010 non-medical transportation | | | | |
| Service Definition (Scope): | | | | | |

- A. Transportation services are designed specifically to improve the person's and the family caregiver's ability to access community activities within their own community in response to needs identified through the participant's person-centered plan.
- B. Transportation services can include, but are not limited to:
 - 1. Orientation services in using other senses or supports for safe movement from one place to another;
 - 2. Accessing Mobility services such as transportation coordination and accessing resources;
 - 3. Travel training such as supporting the participant and his or her family in learning how to access and use informal, generic, and public transportation for independence and community integration;
 - 4. Transportation services provided by different modalities, including: public and community transportation, taxi services, transportation specific prepaid transportation cards, mileage reimbursement, volunteer transportation, and non-traditional transportation providers; and
 - 5. Purchase of prepaid transportation vouchers and cards, such as the Charm Card and Taxi Cards.

SERVICE REQUIREMENTS:

- A. Services are available to the participant living in their own home or in the participant's family home.
- B. For participants self-directing their services, the transportation budget is based on their need while considering their preferences and funds availability from their authorized person-centered plan and budget.
- C. The Program will not make payment to spouses or legally responsible individuals for furnishing transportation services.
- D. A relative (who is not a spouse or legally responsible person) of a participant participating in Self-Directed Services may be paid to provide this service, however, the DDA must pre-approve such payment in accordance with the applicable requirements set forth in Appendix C-2.
- E. Payment rates for services must be customary and reasonable as established or authorized by the DDA.
- F. Transportation services shall be provided by the most cost-efficient mode available and shall be wheelchair accessible when needed.
- G. Transportation services will not be covered when transportation is part of another waiver service including but not limited to Personal Supports services.
- H. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the participant's file.
- I. To the extent that any listed services are covered under the Medicaid State Plan, the services under the waiver would be limited to additional services not otherwise covered under the Medicaid State Plan, but consistent with waiver objectives of avoiding institutionalization.

J.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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| Service Delivery X Method (check each that applies): | | Participant-directed as specified in Appendix E | | | | E | X | Provider managed | | |
|--|--------|---|----------|----------------------------------|---------|---|---|--|--|---|
| Specify whether the may be provided by each that applies): | | | | Legally Responsible Person | | Relati | | | Legal (| Guardian |
| | | | | Provider S | Specifi | cations | S | | | |
| Provider | X | Inc | lividual | . List types: | | X | Agency | y. List t | he type: | s of agencies: |
| Category(s) (check one or both): | | idual - ted ser | | rticipants self- | | DDA Certified Organized Health Care Delivery System Provider | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Provider Qualifica | ations | | | | | | | | | |
| Provider Type: | Licer | nse (sp | ecify) | Certificate | (speci) | fy) | | Other S | tandard | (specify) |
| Individual/Entity – for self- directed services | | | | | | | redential providing contract of same ava. FMS mu performing qualificate the service. 1. For intranspostand. a. Be at b. Currect. c. Passinves backgoverifical C-2-and. d. Possevenical and e. Have automand/of can. 2. Orient Train have. | Is of indiginal services or emploidable up st ensuring the services ions not be being individual portation ards are least 18 ent first a criminal tigation ground of cations are automorphises a value or hired are. | es with voys and poor require the intervice meter belo provide als proven, the formal back and and hall back and any checks a sproven belo insected belo provided and back and any checks a sproven belo insected belo belo insected belo belo insected belo belo insected b | dividual or entity neets the w as applicable to ed: iding direct illowing minimum ed: bld; CPR certification; |

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| | | entities: a. Easter Seals Project Action (ESPA) b. American Public Transit Association c. Community Transportation Association of America d. National Transit Institute (NTI) e. American Council for the Blind f. National Federation of the Blind g. Association of Travel Instruction h. Other recognized entities based on approval from the DDA |
|--|---|--|
| DDA Certified Organized Health Care Delivery System Provider | DDA certified Organized Health Care Delivery System provider as per COMAR Title 10, Subtitle 22 | OHCDS providers shall verify the licenses and credentials of individuals providing services with whom they contract or employs and have a copy of the same available upon request. OHCDS must ensure the individual or entity performing the service meets the qualifications noted below as applicable to the service being provided: 1. For individuals providing direct transportation, the following minimum standards are required: a. Be at least 18 years old; b. Current first aid and CPR certification; c. Pass a criminal background investigation and any other required background checks and credentials verifications as provided in Appendix C-2-a; d. Possess a valid driver's license for vehicle necessary to provide services; and e. Have automobile insurance for all automobiles that are owned, leased, and/or hired and used in the provision of care. 2. Orientation, Mobility and Travel Training Specialists – must attend and have a current certification as a travel trainer from one of the following entities: a. Easter Seals Project Action (ESPA) b. American Public Transit Association c. Community Transportation Association of America |

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| | • | | | d. e. f. g. h. | Ame Nati Asso Othe | onal Transit Institute (NTI) erican Council for the Blind onal Federation of the Blind ociation of Travel Instruction er recognized entities based on oval from the DDA |
|---|---|--|--|---|-----------------------------|---|
| Provider Type: | on of Provider Qualifications er Type: Entity Responsible for Verification: | | | | Frequency of Verification | |
| Individual – for sel directed services | f- | FMS providers, as described in Appendix E, for verification of provider qualifications | | | • | FMS providers – prior to delivery of services |
| DDA Certified Organized Health Care Delivery System Provider 1. DDA for verification of the Organized Health Care Delivery System certification Organized Health Care Delivery System provider for verification of staff qualification | | 1 | | DDA - Annual for certification OHCDS – prior to service delivery | | |

Service Type: Other Service

Service (Name):

Alternative Service Title: **VEHICLE MODIFICATIONS**

| Service Specification | | | | | | | |
|--|---|--|--|--|--|--|--|
| HCBS Taxonomy | | | | | | | |
| Category 1: | Sub-Category 1: | | | | | | |
| 14: Equipment, Technology, and Modifications | 14020 home and/or vehicle accessibility adaptations | | | | | | |
| Service Definition (Scope): | | | | | | | |

- A. Vehicle modifications are adaptations or alterations to a vehicle that is the participant's or participant's family's primary means of transportation. Vehicle modifications are designed to accommodate the needs of the participant and enable the participant to integrate more fully into the community and to ensure the health, welfare and safety and integration by removing barriers to transportation.
- B. Vehicle modifications may include, but are not limited to:
 - 1. Assessment services to (a) help determine specific needs of the participant as a driver or passenger, (b) review modification options, and (c) develop a prescription for required modifications of a vehicle;
 - 2. Assistance with modifications to be purchased and installed in a vehicle owned by or a new vehicle purchased by the participant, or legally responsible parent of a minor or other caretaker as approved by DDA;
 - 3. Non-warranty vehicle modification repairs; and
 - 4. Training on use of the modification.
- C. Vehicle modifications do not include the purchase of new or used vehicles, general vehicle maintenance or repair, State inspections, insurance, gasoline, fines, tickets, or the purchase of warranties.

SERVICE REQUIREMENTS:

A. All vehicle modifications purchases must be pre-approved in writing by the DDA.

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- B. A vehicle modification assessment and/or a driving assessment will be required when not conducted within the last year by the Division of Rehabilitation Services (DORS).
- C. A prescription for vehicle modifications must be completed by a driver rehabilitation specialist or certified driver rehabilitation specialist. The prescription for vehicle modifications applies only to the year/make/model of the vehicle specified on the Vehicle Equipment and Adaptation Prescription Agreement (VEAPA).
- D. The vehicle owner is responsible for:
 - 1. The maintenance and upkeep of the vehicle; and
 - 2. Purchasing insurance on vehicle modifications. The program will not correct or replace vehicle modifications provided under the program that have been damaged or destroyed in an accident.
- E. Vehicle modifications are only authorized to vehicles meeting safety standards once modified.
- F. The Program cannot provide assistance with modifications on vehicles not registered under the participant or legally responsible parent of a minor or other primary caretaker. This includes leased vehicles.

| | or legally responsible parent of a minor or other primary caretaker. This includes leased vehicles. G. Vehicle modifications may not be provided in day, employment, and residential provider owned vehicles. H. Prior to accessing DDA funding for this service, all other available and appropriate funding sources, including but not limited to those offered by Maryland Medicaid State Plan, Division of Rehabilitation Services ("DORS"), State Department of Education, and Department of Human Resources, must be explored and exhausted. These efforts must be documented in the participant's file. I. To the extent that any listed services are covered under the State plan, the services under the waiver would be limited to additional services not otherwise covered under the State plan, but consistent with waiver objectives of avoiding institutionalization. | | | | | | | |
|-------------------------|---|--------------------------|---|---------|---|---------------------------------------|--------------------------------|---|
| Spe | cify applicable (| if any) limits on the an | nount, frequency, or | r durat | ion of this s | ervice | : | |
| | Vehicle modifications payment rates for services must be customary, reasonable according to current market values, and may not exceed a total of \$15,000 over a ten year period, unless otherwise authorized by DDA. | | | | | | | |
| | Service Delivery Method (check each that applies): Participant-directed as specified in Appendix E X Provider managed | | | | | | | |
| be p | Specify whether the service may be provided by (check each that applies): Legally Relative Relative Person Legal Guardian | | | | | | | |
| Provider Specifications | | | | | | | | |
| | vider | Individual. | List types: | X | Agency. | List | the type | es of agencies: |
| | egory(s) eck one or | | | | DDA Certified Organized Health Care Delivery System Provider | | | |
| Don | .,. | | | | | | | services - Division ORS) Vendor |
| | | | | | | | | |
| Pro | vider Qualifica | tions | | | | | | |
| Pro | vider Type: | License (specify) | Certificate (spec | rify) | (| Other S | Standard | d (specify) |
| Org Car | A Certified anized Health e Delivery tem Provider | | DDA certified Organized Health Care Delivery Sys Providers as per COMAR Title 10 Subtitle 22 | stem | credentials profession employs as available to | s, and als wi nd hav ipon re | experienth whome a coppequest. | verify the licenses, nce of all n they contract or y of the same |
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| | | entity performing the service meets the qualifications noted below: 1. DORS approved vendor or DDA approved vendor; 2. Vehicle Equipment and Adaptation Prescription Agreement (VEAPA) must be completed by a driver rehabilitation specialist or certified driver rehabilitation specialist; and 3. The adaptive driving assessment specialist who wrote the Adapted Driving Assessment report and the VEAPA shall ensure the vehicle modification fits the consumer and the consumer is able to safely drive the vehicle with the new adaptations/equipment by conducting an on-site assessment and provide a statement as to whether it meets the individual's needs. |
|--|--|---|
| For participants self-directing services - Division of Rehabilitation Services (DORS) Vendor | | The following minimum standards are required: A. Entity designated by the Division of Rehabilitation Services (DORS) as a Vehicle Modification service vendor. B. The Adapted Driving Assessment specialist who wrote the Adapted Driving Assessment report and the VEAPA shall ensure the vehicle modification fits the consumer and the consumer is able to safely drive the vehicle with the new adaptations/equipment by conducting an on-site assessment and provide a statement to meet the individual's needs. |
| Verification of Provid | er Qualifications | |
| Provider Type: | Entity Responsible for Verification | · |
| DDA Certified Organized Health Care Delivery System Provider | DDA for verification of the OHCDS certification OHCDS providers for entities and incomplete they contract or employ | annually |

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| For participants self- | FMS provider, as described in Appendix E | Prior to service delivery |
|-------------------------|--|---------------------------|
| directing services - | | |
| Division of | | |
| Rehabilitation Services | | |
| (DORS) Vendor | | |

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

| 0 | Not | Not applicable – Case management is not furnished as a distinct activity to waiver participants. | | | |
|---|-----|--|--|--|--|
| X | | Applicable – Case management is furnished as a distinct activity to waiver participants. Check each that applies: | | | |
| | | ☐ As a waiver service defined in Appendix C-3 (do not complete C-1-c) | | | |
| | | As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). <i>Complete item C-1-c</i> . | | | |
| | X | As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c</i> . | | | |
| | | As an administrative activity. Complete item C-1-c. | | | |

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Private community service providers and local Health Departments provide Coordination of Community Service (case management) on behalf of waiver participant as per COMAR.

Appendix C-2: General Service Specifications

- **a.** Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-(select one):
 - Yes. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

This section describes the minimum background check and investigation requirements for providers under applicable law. A provider may opt to perform additional checks and investigations as it sees fit.

Criminal Background Checks

The DDA's regulation requires that each DDA-licensed provider complete either: (1) a State criminal history records check via the Maryland Department of Public Safety's Criminal Justice Information System; or (2) a National criminal background check via a private agency, with

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whom the provider contracts. If the provider chooses the second option, the criminal background check must pull court or other records "in each state in which [the provider] knows or has reason to know the eligible employee [or contractor] worked or resided during the past 7 years."

The provider must complete this requirement for all of the provider's employees and contractors, regardless of their roles and responsibilities. If this background check identifies a criminal history that "indicate[s] behavior potentially harmful" to individuals receiving services, then the provider is prohibited from employing or contracting with the individual. See Code of Maryland Regulations (COMAR) 10.22.02.11, Maryland Annotated Code Health-General Article § 19-1901 *et seq.*, and COMAR Title 12, Subtitle 15.

Child Protective Services Background Clearance

The State also maintains a Centralized Confidential Database that contains information about child abuse and neglect investigations conducted by the Maryland State Local Departments of Social Services. Staff engaging in one-to-one interactions with children under the age of 18 must have a Child Protective Services Background Clearance.

State Oversight of Compliance with These Requirements

The DDA, OHS, and OHCQ review providers' records for completion of criminal background checks, in accordance with these requirements, during surveys, site visits, and investigations. Annually the DDA will review Fiscal Management Services providers' records for required background checks of staff working for participants enrolled in the Self-Directed Services Delivery Model, described in Appendix E.

- No. Criminal history and/or background investigations are not required.
- **b. Abuse Registry Screening**. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):
 - Yes. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
 - X No. The State does not conduct abuse registry screening.
- c. Services in Facilities Subject to \$1616(e) of the Social Security Act. Select one:
 - X No. Home and community-based services under this waiver are not provided in facilities subject to \$1616(e) of the Act. *Do not complete Items C-2-c.i-c.iii*.
 - Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). Complete Items C-2-c.i -c.iii.

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| i. | Types of Facilities Subject to §1616(e). | Complete the | following | table for | or each | type | of f | facility |
|----|--|--------------|-----------|-----------|---------|------|------|----------|
| | subject to §1616(e) of the Act: | | | | | | | |

| Type of Facility | Waiver Service(s) Provided in Facility | Facility Capacity Limit |
|------------------|--|----------------------------|
| | | |

| individuals unrelated to the proprietor, describe | facilities subject to §1616(e) that serve four or more how a home and community character is maintained in |
|---|--|
| these settings. | |
| | |

iii. Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following (*check each that applies*):

| Standard | Topic Addressed |
|---|--------------------|
| Admission policies | |
| Physical environment | |
| Sanitation | |
| Safety | |
| Staff: resident ratios | |
| Staff training and qualifications | |
| Staff supervision | |
| Resident rights | |
| Medication administration | |
| Use of restrictive interventions | |
| Incident reporting | |
| Provision of or arrangement for necessary health services | |

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of

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the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- X No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.
- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. Select one:
 - O The State does not make payment to relatives/legal guardians for furnishing waiver services.
 - The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.

Circumstances When Payment May be Made

A participant enrolled in the Self-Directed Services Delivery Model (as provided in Appendix E) may use a relative (who is not a spouse or legally responsible individual) to provide services in the following circumstances, as documented in the participant's Person-Centered Plan (PCP):

- 1. Lack of qualified provider in remote areas of the State;
- 2. Lack of qualified provider who can furnish services at necessary times and places;
- 3. Unique ability of relative to meet the needs of the participant (e.g. has special skills or training like nursing license);

Definitions of Relative, Legal Guardian, Spouse, and Legally Responsible Person.

Relative

For purposes of this waiver, a relative is defined as parents, siblings, uncles, aunts, grandparents, cousins, nieces and nephews.

The following types of relatives may be paid to provide services:

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Legal Guardian

For purposes of this waiver, a legal guardian is defined as an individual or entity who has obtained a valid court order stating that the individual is the legal guardian of the person of the participant pursuant to Maryland Annotated Code's Family Law or Estates & Trusts Articles.

Spouse

For purposes of this waiver, a spouse is defined as an individual legally married under applicable law to the participant.

Legally Responsible Person

A legally responsible person is defined as a person who has a legal obligation under the provisions of Maryland law to care for another person. Under Maryland law, this includes: (1) a parent (either natural or adoptive), legal guardian, or person otherwise legally responsible for the care of a minor (e.g., foster parent or relative appointed by court); and (2) an individual – not a provider agency – legal guardian of a vulnerable adult's person granted by court order the duty to "provide care, comfort, and maintenance of the disabled person" and other duties related to providing for the individual's daily needs.

Services for Which Payment May be Made

As specified in Appendix C-1/C-3 and this Appendix C-2-e, relatives may be paid to furnish the following services: (1) Community Development Services; (2) Personal Supports; (3) Respite Care; (4) Support Broker; and (5) Supported Employment.

Safeguards

To insure the use of a relative (who is not a spouse or legally responsible individual) to provide services is in the best interest of the participant, the following criteria must be documented in the participant's Person-Centered Plan (PCP):

- 1. Choice of provider truly reflects the participant's wishes and desires;
- 2. The provision of services by the relative is in the best interests of the individual and family;
- 3. The provision of services by the relative is appropriate and based on the participant's identified support needs;
- 4. The services provided by the relative will increase the participant's independence and community integration;
- 5. There are documented steps in the PCP that will be taken to expand the participant's circle of support so that he or she is able to maintain and improve his or her health, safety, independence, and level of community integration on an ongoing basis should the relative acting in the capacity of employee be no longer be available; and
- 6. A Supportive Decision Making (SDM) agreement is established that identifies the people (beyond family members) who will support the participant in making her or his own decisions.
- 7. The relative must sign agreement to provide assurances to DDA that they will implement the PCP and provide the services in accordance with applicable federal and State laws and regulations governing the program.

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| | State's Oversight Procedures The DDA will conduct a random selected statistically valid sample of services provided by relatives or legal guardians to ensure payment is made only for services rendered and the services rendered are in the best interest of the participant. |
|---|--|
| 0 | Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3. Specify the controls that are employed to ensure that payments are made only for services rendered. |
| | |
| 0 | Other policy. Specify: |
| | |

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Interested community agencies and other providers can submit the DDA application and required attachments at any time. For services that require a DDA license, applicants that meet requirements are then referred to the Office of Health Care Quality to obtain the license.

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

- i. Sub-Assurances:
 - a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
 - i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

| Performance | QP-PM1 Number and percent of newly enrolled waiver providers who meet | | | | | |
|---|---|-------------------|-------------------|--|--|--|
| Measure: | required licensure, regulatory and applicable waiver standards prior to service | | | | | |
| | provision. | | | | | |
| Data Source (Select one) (Several options are listed in the on-line application): DDA | | | | | | |
| If 'Other' is selected, specify: | | | | | | |
| | | | | | | |
| | Responsible Party for | Frequency of data | Sampling Approach | | | |

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| data collection/generation (check each that applies) | collection/generation: (check each that applies) | (check each that applies) |
|--|--|----------------------------------|
| ☐ State Medicaid Agency | □ Weekly | X 100% Review |
| X Operating Agency | \square Monthly | □ Less than 100% Review |
| \square Sub-State Entity | X Quarterly | \square Representative |
| | | Sample; Confidence Interval = |
| ☐ Other Specify: | □Annually | |
| | \square Continuously and | \square Stratified: |
| | Ongoing | Describe Group: |
| | ☐ Other Specify: | |
| | | ☐ Other Specify: |
| | | |

| Responsible Party for | Frequency of data |
|--------------------------|--------------------------|
| data aggregation and | aggregation and |
| analysis | analysis: |
| (check each that applies | (check each that applies |
| ☐ State Medicaid Agency | ☐ Weekly |
| X Operating Agency | \square Monthly |
| ☐ Sub-State Entity | X Quarterly |
| □ Other | \square Annually |
| Specify: | |
| | ☐ Continuously and |
| | Ongoing |
| | □ Other |
| | Specify: |
| | |

| Performance Measure: | QP-PM2 Number and percent of providers who continue to meet required licensure and initial QP standards. | | |
|----------------------------|--|---|--|
| | 2 | | |
| Data Source (Select one | e) (Several options are listed | in the on-line application |): DDA |
| If 'Other' is selected, sp | pecify: | | |
| | | | |
| | Responsible Party for data collection/genera tion (check each that applies) | Frequency of data collection/gene ration: (check each that applies) | Sampling Approach (check each that applies) |
| | ☐ State Medicaid Agency | □Weekly | X 100% Review |
| | X Operating Agency | □ Monthly | □Less than 100% |

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| | | Review |
|--------------------|--------------------|------------------|
| ☐ Sub-State Entity | X Quarterly | ☐ Representative |
| | | Sample; |
| | | Confidence |
| | | Interval = |
| □ Other | $\square Annually$ | |
| Specify: | | |
| | ☐ Continuously and | ☐ Stratified: |
| | Ongoing | Describe |
| | | Group: |
| | □ Other | |
| | Specify: | |
| | | ☐ Other Specify: |
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| Frequency of data |
| aggregation |
| and analysis: |
| (check each that |
| applies |
| ☐ Weekly |
| |
| ☐ Monthly |
| X Quarterly |
| ☐ Annually |
| |
| ☐ Continuously and |
| Ongoing |
| □ Other |
| Specify: |
| |
| |

- b Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
 - i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

| Performance Measure: | QP-PM3 Number and percent of newly enrolled non-licensed or non-certified waiver providers who meet regulatory and applicable waiver standards prior to service provision. | | |
|---|--|------------------------|---------------------------|
| Data Source (Select one) (Several options are listed in the on-line application): DDA | | | |
| If 'Other' is selected, specify: | | | |
| | | | |
| | Responsible Party for | Frequency of data | Sampling Approach |
| | data | collection/generation: | (check each that applies) |
| | collection/generation | (check each that | |

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| (check each that applies) | applies) | |
|---------------------------|--------------------|--------------------------|
| ☐ State Medicaid Agency | □Weekly | □ 100% Review |
| X Operating Agency | ☐ Monthly | X Less than 100% Review |
| ☐ Sub-State Entity | X Quarterly | X Representative |
| | | Sample; Confidence |
| □ Other | // Ammually | Interval =95 |
| Specify: | \square Annually | |
| | ☐ Continuously and | ☐ Stratified: |
| | Ongoing | Describe Group: |
| | □ Other | |
| | Specify: | |
| | | \square Other Specify: |
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| Frequency of data |
| aggregation and |
| analysis: |
| (check each that applies |
| ☐ Weekly |
| □Monthly |
| X Quarterly |
| □Annually |
| |
| ☐ Continuously and |
| Ongoing |
| □ Other |
| Specify: |
| |
| |

Add another Performance measure (button to prompt another performance measure)

- c Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.
 - i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

| Performance | QP-PM4 Number and percent of enrolled licensed providers who meet training | | | |
|---|--|-------------------|-------------------|--|
| Measure: | requirements in accordance with the approved waiver. | | | |
| | | | | |
| Data Source (Select one) (Several options are listed in the on-line application): DDA | | | | |
| If 'Other' is selected, specify: | | | | |
| | | | | |
| | Responsible Party for | Frequency of data | Sampling Approach | |

| State: | |
|----------------|--|
| Effective Date | |

| data collection/generation (check each that applies) | collection/generation: (check each that applies) | (check each that applies) |
|--|--|---------------------------|
| ☐ State Medicaid Agency | □Weekly | □ 100% Review |
| X Operating Agency | \square Monthly | X Less than 100% Review |
| \square Sub-State Entity | X Quarterly | X Representative |
| | | Sample; Confidence |
| | | Interval = 95 |
| \square Other | \square Annually | |
| Specify: | | |
| | ☐ Continuously and | ☐ Stratified: |
| | Ongoing | Describe Group: |
| | □ Other | |
| | Specify: | |
| | | ☐ Other Specify: |
| | | |

| Data High Cgatton and Hin | uysis |
|---------------------------|--------------------------|
| Responsible Party for | Frequency of data |
| data aggregation and | aggregation and |
| analysis | analysis: |
| (check each that applies | (check each that applies |
| ☐ State Medicaid Agency | ☐ Weekly |
| X Operating Agency | \square Monthly |
| ☐ Sub-State Entity | X Quarterly |
| □ Other | \square Annually |
| Specify: | |
| | ☐ Continuously and |
| | Ongoing |
| | □ Other |
| | Specify: |
| | |

b. Methods for Remediation/Fixing Individual Problems

i Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DDA's Provider Relations staff provides technical assistance and support on an on-going basis to licensed providers and will address specific remediation issues. Based on the identified issues, a variety of remediation strategies may be used including conference call, letter, in person meeting, and training. These remediation efforts will be documented in the provider's file.

ii Remediation Data Aggregation

| State: | |
|----------------|--|
| Effective Date | |

| Remediation-related | Responsible Party (check | Frequency of data |
|-----------------------|--------------------------|---------------------------|
| Data Aggregation and | each that applies) | aggregation and |
| Analysis (including | | analysis: |
| trend identification) | | (check each that applies) |
| | ☐ State Medicaid Agency | □Weekly |
| | X Operating Agency | \square Monthly |
| | ☐ Sub-State Entity | X Quarterly |
| | ☐ Other: Specify: | \square Annually |
| | | ☐ Continuously and |
| | | Ongoing |
| | | ☐ Other: Specify; |
| | | |

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

| X | No |
|---|--|
| 0 | Yes |
| | Please provide a detailed strategy for assuring Qualified Providers, the specific |
| | timeline for implementing identified strategies, and the parties responsible for its |
| | operation. |

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*check each that applies*).

| X | Not applicable – The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3. |
|---|---|
| 0 | Applicable – The State imposes additional limits on the amount of waiver services. |

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

| Limit(s) on Set(s) of Services . There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. <i>Furnish the information specified above</i> . |
|---|
| |
| Prospective Individual Budget Amount . There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above</i> . |

| State: | |
|----------------|--|
| Effective Date | |

| Budget Limits by Level of Support . Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. <i>Furnish the information specified above</i> . | |
|---|--|
| | |
| Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i> | |
| | |
| | |

Appendix C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

- 1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
- 2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Community Supports Waiver services include various employment, meaningful day, and support services.

Services are provided in the community or the individual's own home or a with the exception of the following services for which the sites must comply with the HCB settings requirement prior to enrollment as a waiver service provider:

Day Habilitation services are provided at provider operated sites and in the community.

Transitional Employment –facility based services are provided at provider operated sites

Medical Day Care services are provided at provider operated sites and in the community.

Respite Care Services can be provided in the participant's home, a community setting, a Youth Camp certified by DHMH, or a site licensed by the Developmental Disabilities Administration.

There are no residential services provided.

The DDA will review conduct site visits for site based services to confirm compliance with the HCB settings requirement prior to enrollment of the provider as a Medicaid waiver service provider under the Community Supports Waiver.

| State: | |
|----------------|--|
| Effective Date | |